

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03644

## CERTIFICATE OF DEATH

03638

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>			
c. LENGTH OF STAY IN 1b <u>P.O.A</u>				d. STREET ADDRESS <u>913 S. WASHINGTON ST</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>							
3. NAME OF DECEASED (Type or print) <u>ERNEST</u>		First		Middle		Last	
4. DATE OF DEATH <u>MARCH 6</u>		Month		Day		Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 17 1909</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>GEORGE T. ALLEN</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE LOUISE POWELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>220-07-1321</u>			
17. INFORMANT <u>MRS. GLADYS WOOD</u>				Address <u>2606 KIRKWOOD PLACE HYATTSVILLE MD 20782</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>66</u> , to <u>MARCH 6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MARCH 6</u> , 19 <u>67</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>E. J. SIMON</u>				22b. DATE SIGNED <u>3-7-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. J. SIMON</u>				22d. ADDRESS <u>HAURE DE GRACE, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR. 9 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SALEM CHURCH YARD</u>		23d. LOCATION (City, town or county) (State) <u>SPOTSVANILA CO. VA.</u>	
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. DATE <u>MAR 9 1967</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03645		03639									
1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural) Forest Hill</b> c. LENGTH OF STAY IN b <b>2 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cooptown Road</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Forest Hill</b> d. STREET ADDRESS <b>Cooptown Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>James Amos</b>			4. DATE OF DEATH <b>March 19, 1967</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>Colored</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>May 21, 1873</b>			9. AGE (In years last birthday) <b>93 yrs.</b>			10. IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Jarrettsville, Md.</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>James Amos</b>						14. MOTHER'S MAIDEN NAME <b>Mary Hall</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>218-18-2326</b>					
17. INFORMANT <b>W. Elwood Amos</b>						Address <b>Cooptown Road Forest Hill, Md. 21050</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> 4221 } DUE TO (b) <b>Arteriosclerotic cardio + cerebro-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>676</b>			20f. (City or town) <b>Forest Hill</b> (County) <b>Harford</b> (State) <b>Md.</b>		
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>3/13</b> 19 <b>67</b> , to <b>3/19</b> 19 <b>67</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>3/13</b> 19 <b>67</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>James F. White, Jr.</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>3/20/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>James F. White, Jr. M.D.</b>						22d. ADDRESS <b>Jarrettsville, Maryland.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3/22/1967</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Fairview A.M.E.</b>			23d. LOCATION (City, town or county) <b>Forest Hill, Maryland</b> (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Kurtz</b>						ADDRESS <b>Jarrettsville, Md.</b>			25. REC'D BY REGISTRAR <b>MAR 21 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles E. Kurtz</b>		

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VR A15 (4)  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>						c. LENGTH OF STAY IN ID <u>6 hrs.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp</u>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>W.</u> Last <u>Asbury</u>						4. DATE OF DEATH Month <u>MARCH</u> Day <u>3</u> Year <u>1967</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 19, 1920</u>		9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>				11. BIRTHPLACE (County & State, or foreign country) <u>HARFORD CO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES COMBS</u>						14. MOTHER'S MAIDEN NAME <u>EDITH SCARBOROUGH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>CLYDE ASBURY, STREET, MD.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X Congestive Heart Failure</u>										INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>metastatic carcinoma to lung</u>										24 hrs	
DUE TO (c) <u>carcinoma of breast</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> IN <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1</u> , 1967, to <u>March 3</u> , 1967, that (I) (we) last saw the deceased alive on <u>MARCH 3</u> 1967, and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Dudley Phillips</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>3/3/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>						22d. ADDRESS <u>Darlington MD 2034</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>MAR 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FELLOWSHIP</u>			23d. LOCATION (City, town or county) (State) <u>PULESVILLE, HARFORD CO., MD.</u>			
24. FUNERAL DIRECTOR <u>John H. Hawkins</u>						ADDRESS <u>DELTA, PA.</u>		25a. REC'D BY REGISTRAR   25b. REGISTRAR'S SIGNATURE DATE <u>MAR 7 1967</u> <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>					c. LENGTH OF STAY IN 1b <b>2 yrs.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Harford Convalescent Home</b>					d. STREET ADDRESS <b>Ady Road</b>				
3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>T.</b> Last <b>Barrow</b>					4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1967</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/9/1936</b>		9. AGE (In years last birthday) <b>30</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Dublin, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John C. Tennant</b>					14. MOTHER'S MAIDEN NAME <b>Annie Jones</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>217-36-4583</b>		17. INFORMANT <b>James W. Barrow</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4/201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <b>Chr. Arterio-sclerotic C.V.D.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , <b>1942</b> , to <b>Mar. 4</b> , <b>1967</b> , that (I) <del>had</del> last saw the deceased alive on <b>Mar. 3</b> , <b>1967</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Willard P. Hudson</b> M.D.								22b. DATE SIGNED <b>March 4, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Willard P. Hudson, M.D.</b>					22d. ADDRESS <b>Forest Hill, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3/6/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Thomas Run</b>		23d. LOCATION (City, town or county) (State) <b>Bel Air, Maryland</b>		
24. FUNERAL DIRECTOR <b>Charles E. Kurtz</b> Jarrettsville, Md.					25a. REC'D BY REGISTRAR <b>DATE MAR 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <i>Harford Maryland</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harde Chase, Md.</i> c. LENGTH OF STAY IN b. <i>40 yrs</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harde Chase, Md.</i> d. STREET ADDRESS <i>609 N. Stokes St.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Nicola Bernardi</i> First Middle Last				4. DATE OF DEATH <i>3/3/67</i> Month Day Year			
5. SEX <i>Male</i>		6. COLOR OF RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/4/1891</i>	
9. AGE (In years last birthday) <i>75</i>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cement Linisher</i>		11. BIRTH PLACE (County & State, or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>	
13. FATHER'S NAME <i>Joseph Bernardi</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Joseph Bernardi</i> Address <i>643 E. Erie St., Harde Chase, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Coronary of lung</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH <i>2-3 months</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		22. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 7</i> , 19 <i>66</i> , to <i>March 3</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>March 3</i> , 19 <i>67</i> , and that death occurred at <i>P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Edward J. Simon</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>3-4-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>EDWARD J. SIMON</i>				22d. ADDRESS <i>Harde Chase, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>3/6/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Elm</i>		23d. LOCATION (City, town or county) (State) <i>Harde Chase, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William J. Ryan</i> ADDRESS <i>Harde Chase, Md.</i>				25a. REC'D BY REGISTRAR <i>NOTE</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

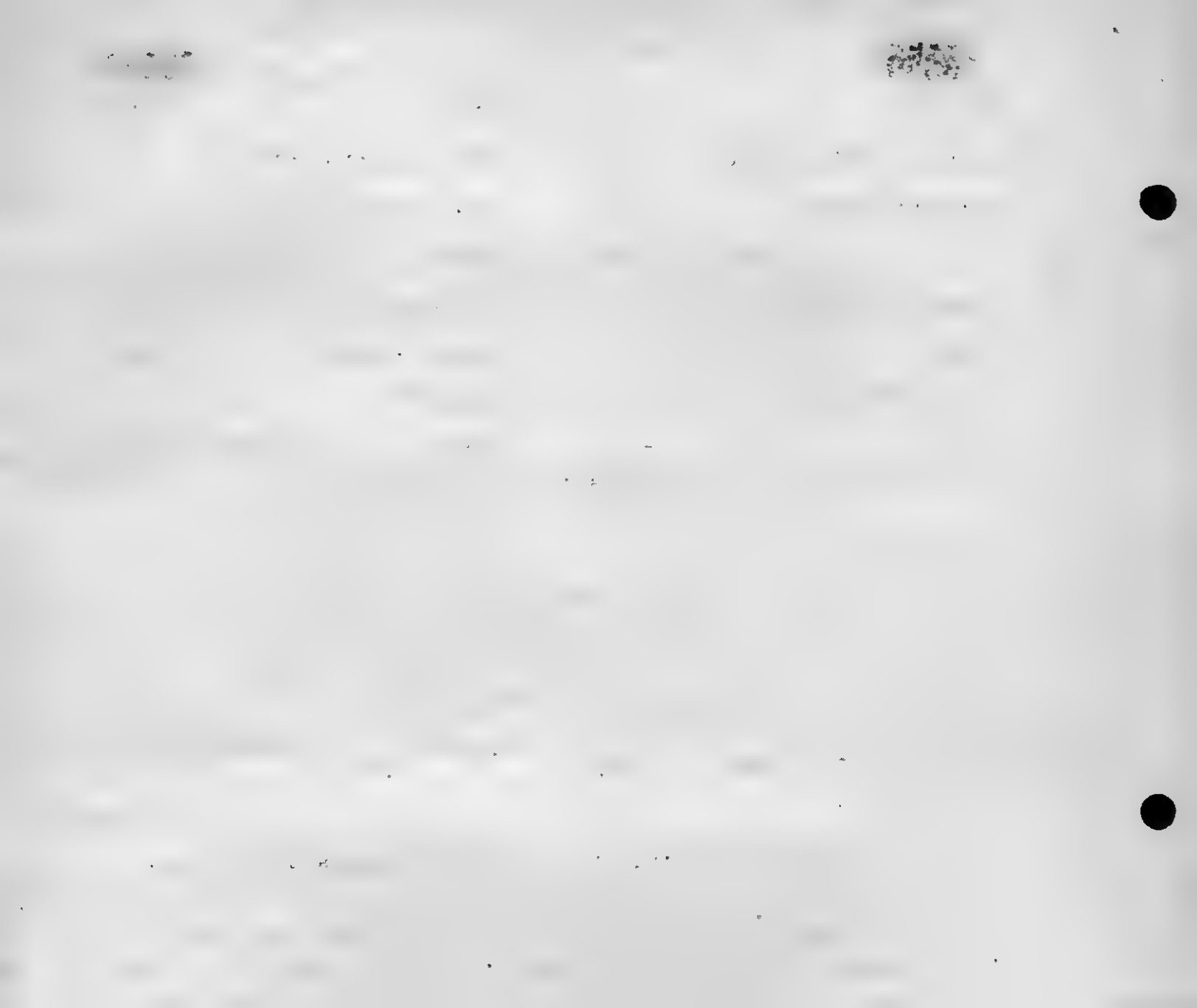
50260

50260

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03649 CERTIFICATE OF DEATH 03643											
1. PLACE OF DEATH a. COUNTY <b>Harford</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Havre De Grace, Maryland</b>					
c. LENGTH OF STAY IN 1b <b>1 Day</b>						d. STREET ADDRESS <b>3 E. Robinhood Road</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kirk Army Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carla Sue BINION</b>						4. DATE OF DEATH Month Day Year <b>March 4 1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 February 1967</b>		9. AGE (In years last birthday) yrs. Months Days <b>21</b>		IF UNDER 1 YEAR Months Days <b>21</b>	
IF UNDER 24 HRS. Hours Min. <b>21</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harford, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Lloyd BINION</b>						14. MOTHER'S MAIDEN NAME <b>Linda Ross</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give year or dates of service] <b>-</b>						16. SOCIAL SECURITY NO. <b>-</b>					
17. INFORMANT <b>Father</b>						Address <b>(Same as above)</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningitis Group D Streptococcus (Enterococcus)</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>-</b> (c) <b>-</b> (e), stating the underlying cause last. DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>-</b>										INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) <b>-</b>		20g. (County) <b>-</b>		20h. (State) <b>-</b>	
21. I certify that <b>she</b> (this hospital) attended the deceased from <b>4 Mar (0300), 1967</b> , to <b>4 Mar (2045), 1967</b> that <b>she</b> (we) last saw the deceased alive on <b>4 Mar 1967</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Leland Wight</b>						22b. DATE SIGNED <b>6 March 1967</b>					
22c. PHYSICIAN'S NAME (Type) <b>LELAND WIGHT, CPT., MC</b>						22d. ADDRESS <b>Kirk Army Hospital, APG, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>19 Mar. 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery, Baltimore</b>				23d. LOCATION (City, town or county) (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tarring Funeral Home</b>						25a. REC'D BY REGISTRAR <b>MAR 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>-</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 03644

03650

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		c. LENGTH OF STAY IN 1b <u>2 YRS 3 MOS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1226 GRAFTON SHOP Rd.</u>		e. STREET ADDRESS <u>4308 LASALLE AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNE MUELLER BLICK</u>		4. DATE OF DEATH Month Day Year <u>MARCH 8 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 20, 1892</u>
9. AGE (In years last birthday) yrs. <u>74</u>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STENOGRAPHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CITY BALTIMORE</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE MUELLER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH HERMANN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO <u>215-48-9268</u>	
17. INFORMANT <u>MARIA KILDUFF, BELAIR, Md. (DAUGHTER)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALNUTRITION - ANOREXIA - GENERALIZED</u> <u>METASTASES</u> DUE TO <u>ADENO-CARCINOMA - RECTUM</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u> <u>NOV 1964</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 7</u> , 19 <u>65</u> , to <u>MARCH 8</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>MARCH 8, 1967</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Philip W. Helman</u> M.D. <u>307 HICKORY AVE.</u> <u>MARCH 8, 1967</u> PHYSICIAN'S NAME (Type) <u>PHILIP W. HELMAN, M.D.</u> <u>BEL AIR, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/11/67.</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hickory, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		24a. REC'D BY REGISTRAR <u>MAR 10 1967</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03651

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03645

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>DOA Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Singer Road</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Eliza M. Bradley</u>				4 DATE OF DEATH <u>March 29 1967</u>			
5 SEX <u>F</u>		6 COLOR OR RACE <u>C</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>2-28-1899</u> 68 yrs	
9 AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Harford County, Md.</u>	
13. FATHER'S NAME <u>Steven Peaker</u>				14. MOTHER'S MAIDEN NAME <u>Frances Wright</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>216-30-8346</u>		17. INFORMANT <u>James S. Bullock Hatten, Joppa, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>200X Coronary Occlusion</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				22. DATE SIGNED <u>3-30-67</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>General</u>		23b. DATE THEREOF <u>April 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John Meth. Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Joppa Harford, Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur J. Bullock Harford, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

03652

03646

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u> c. LENGTH OF STAY IN 1b <u>40 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Jarrettsville Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u> d. STREET ADDRESS <u>Jarrettsville Road</u>	
3. NAME OF DECEASED (Type or print) <u>George Albert Brookhart</u> First Middle Last		4. DATE OF DEATH <u>March 10, 1967</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1892</u> Yrs. Months Days
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
10. BIRTHPLACE (County & State, or foreign country) <u>Rutledge, Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
12. FATHER'S NAME <u>George E. Brookhart</u>		13. MOTHER'S MAIDEN NAME <u>Nancy Cochran</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		15. SOCIAL SECURITY NO. <u>215-24-2061</u>	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		17. INFORMANT <u>Helen L. Brookhart</u> Address <u>Jarrettsville, Md.</u> 21084 INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years</u>	
18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20d. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/27, 1967</u> to <u>3/10, 1967</u> , that (I) (the) last saw the deceased alive on <u>3/10, 1967</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James F. White Jr.</u> M.D.		22b. DATE SIGNED <u>3/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES F. WHITE JR M.D.</u>		22d. ADDRESS <u>Jarrettsville, Maryland 21084</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/13/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jarrettsville</u>	23d. LOCATION (City, town or county) (State) <u>Jarrettsville, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kurtz</u>		25. REC'D BY REGISTRAR <u>MAR 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>            Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
1. PLACE OF DEATH a. COUNTY		Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Maryland		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Darlington		c. LENGTH OF STAY IN 1b		16 months.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Darlington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)						First Middle Last			4. DATE OF DEATH		
Mable Marie Caruso									Month Day Year March 14 19 67		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
F		W				Aug. 18, 1916		50 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
none				none				Philadelphia Pa.		U.S.A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
J. Frederick Elste						Mable Henkles					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No.				216-14-1159		Frank R. Chell, Jr.		Edgewood, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Liver</u> 1561 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Fall</u> DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor							
20c. TIME OF INJURY Month, Day, Year Hour (a.m.) 9 p.m. 3-11-67				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Darlington, Harford Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md.			
EXAMINER'S NAME (Type) <u>Gerald C. Palmer, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 3-14-67			
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial				Mar. 17, 1967		Trinity Lutheran Cemetery		Joppa Harford Md			
24. FUNERAL DIRECTOR						ADDRESS		25. MAR 16 1967		25b. REGISTRAR'S SIGNATURE	
Howard K. McComas & Son, Abingdon, Md. 21009								DATE		<u>Charles Judge</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03654

## CERTIFICATE OF DEATH

03648

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAIRE de GRACE</u>		c. LENGTH OF STAY IN IB <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		d. STREET ADDRESS <u>434 Washington St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edward</u> Last <u>Chase</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30, 1906</u>	9. AGE (in years lost birthday) <u>60 yrs</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer and Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning House</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Perryman, Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William B. Chase</u>				14. MOTHER'S MAIDEN NAME <u>Mary M. Lennison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>218-16-8317</u>		17. INFORMANT <u>Mrs. Cecelia Jenkins, Aberdeen, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1/ Brochogenic CA Legs Advanced</u> DUE TO <u>2/ Acute Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>ASHD</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>March 2</u> 19 <u>67</u> , and that death occurred at <u>4:45</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				22d. ADDRESS <u>[Signature]</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Aberdeen, Harford Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Otelia J. Bullock, Haire de Grace, Md. 21078</u>				25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03653

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03649

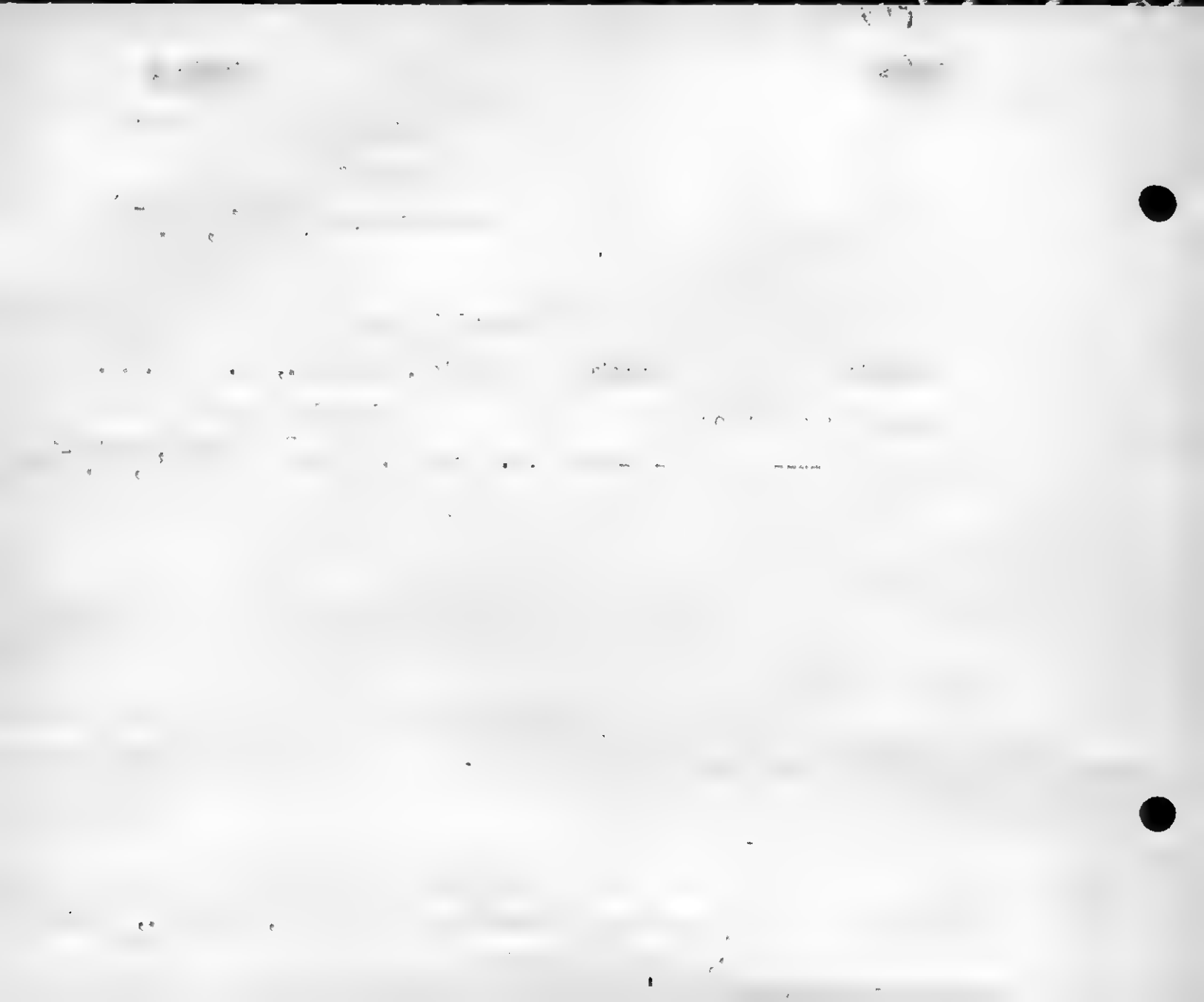
1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial</u>				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 21214			
f. STREET ADDRESS <u>5106 Walther St</u>				6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>M.</u> Last <u>Cress</u>				4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4, 1879.</u>	
9. AGE (in years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Rothe</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Shipley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mildred G. Mueller</u> Address (Same)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Thrombosis</u> (b) <u>A.S. C.V.D.</u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac De-compensation</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>2-11, 1967</u> to <u>3 March 1967</u> , that (I) (we) last saw the deceased alive on <u>3 March 1967</u> , and that death occurred at <u>6 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Loe</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loe, M.D.</u>				22d. ADDRESS <u>Harre de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/6/67.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR, ADDRESS <u>Leonard J. uck, Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in no event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03656		CERTIFICATE OF DEATH				03650			
1 PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRE de GRACE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Creswell</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>					d. STREET ADDRESS <u>(RFD#2, Box 197-1)</u> <u>Creswell Road (Bel Air, Md.)</u>				
3. NAME OF <u>Bertha</u> <u>May</u> <u>Cullop</u> (Type or print) First Middle Last					4. DATE OF DEATH <u>MARCH</u> <u>30</u> <u>1967</u> Month Day Year				
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>April 3, 1902</u>		9 AGE (In years last birthday) <u>64</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS	
10a. USUA. OCCUPAT. OR (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11 BIRTHPLACE (County & State or foreign country) <u>Marion, Smyth Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13 FATHER'S NAME <u>James Preston Orsborne</u>					14. MOTHER'S MAIDEN NAME <u>Effie Ellen Stoots</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>225-32-3747</u>		17. INFORMANT (Husband) <u>734-7535</u> Address <u>RFD#2, Box 197-1 Bel Air, Md. 21014</u> <u>Mr. George S. Cullop</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> DUE TO <u>Unk'd Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Disease</u> (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>3-4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 10th, 1967</u> to <u>March 30, 1967</u> that (I) (we) last saw the deceased alive on <u>Mar 30, 1967</u> , and that death occurred at <u>5:55</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>Edward C. L. Co. M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>3/30/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Edward C. L. Co. M.D.</u>					22d. ADDRESS <u>Harre de Grace, Ind.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Lawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Marion, Smyth Co., Virginia</u>			
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>				25a. REC'D BY REGISTRAR <u>APR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

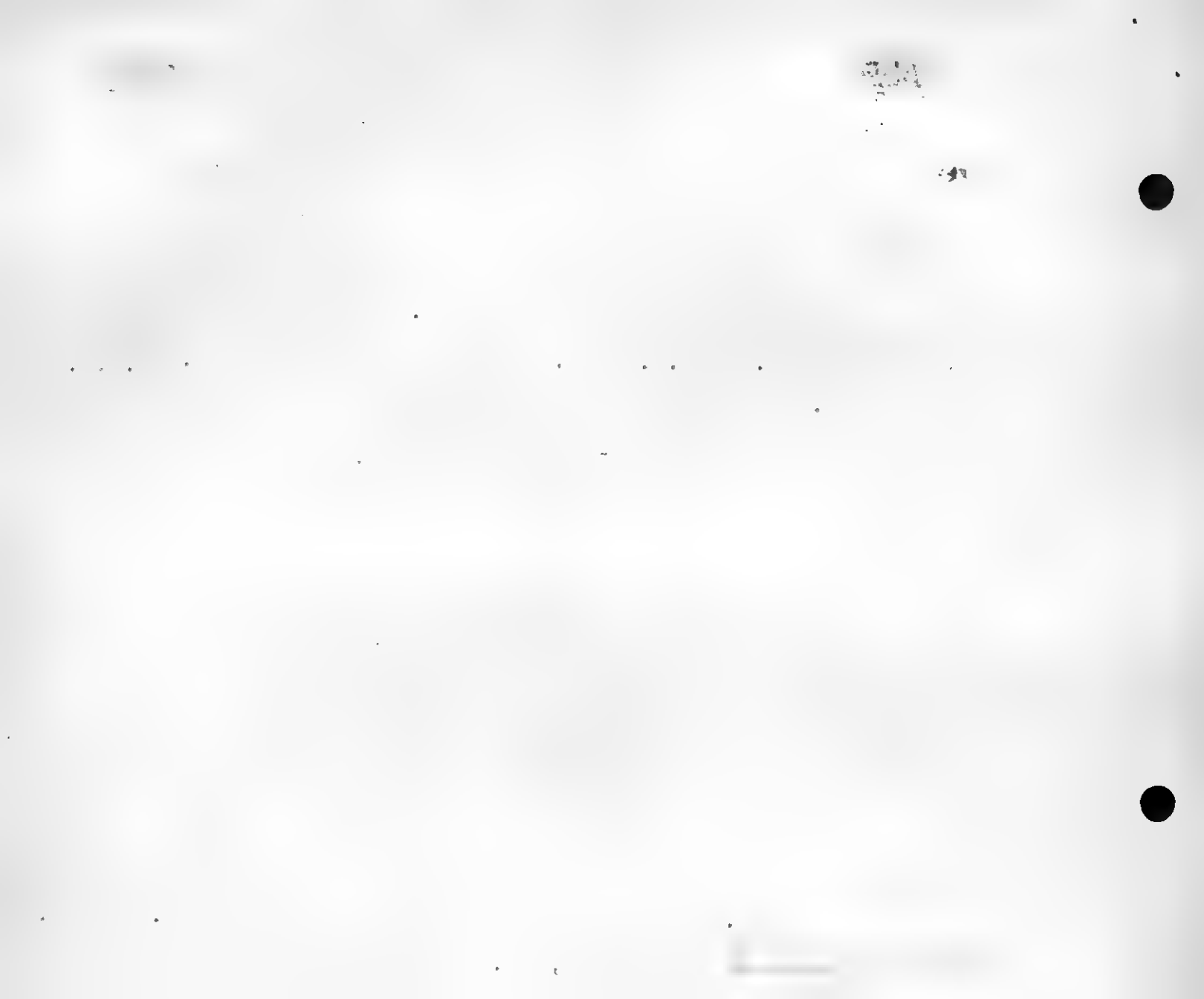
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03657

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03651

1 PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>Abingdon</del> <b>Aberdeen</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>				d. STREET ADDRESS <b>Route #1, Box 154</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM Edward CULLUM</b>				4 DATE OF DEATH Month Day Year <b>March 23 19 67</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>20 Mar. 1891</b>		9 AGE (in years lost birthday) <b>76 yrs</b>		10 UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter (Ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11 BIRTHPLACE (State or foreign country) <b>Baltimore County, Md.</b>		12 C. T. ZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>John L. Cullum (D)</b>				14 MOTHER'S MAIDEN NAME <b>Alice Akers (D)</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>220-22-0292</b>		17 INFORMANT Address <b>Edna Harman. Aberdeen, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple Injuries.</b> 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic Cardiovascular Disease.</b>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>Driver in auto-auto collision.</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>XXXX</b> <b>3/ 21 19 67</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Abingdon Harford Md.</b>	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion, death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>3/23/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>25 Mar. 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spesutia Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Perryman Har. Md.</b>	
24. FUNERAL DIRECTOR <b>Walter Macomber, Jr.</b>				ADDRESS <b>Aberdeen, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



FOR STATE  
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)  
SM 1/65

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03658

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03652

1. PLACE OF DEATH a. COUNTY <u>Hagerstown</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>N.J.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>		d. STREET ADDRESS <u>231 Jersey Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DOA Hagerstown Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruth H Danser</u>		4. DATE OF DEATH Month Day Year <u>March 30 1967</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 13 1921</u>		9. AGE (In years last birthday) <u>46</u> yrs.		10. FUNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>FREDRICKSBURG TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hartman</u>				14. MOTHER'S MAIDEN NAME <u>PAULINE (nee) MAART</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unavailable</u>		17. INFORMANT <u>DANIEL DANSEN</u>		Address <u>231 New Jersey Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>3:30 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40</u>		20f. (City or town) (County) (State) <u>Brooklyn N.J.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerard E Palmer</u>		M.D. ASSISTANT MEDICAL EXAMINER <u>Be/A</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>3-30-67</u>	
EXAMINER'S NAME (Type) <u>Gerard E Palmer</u>		Address (Street, city, town, or county) <u>Brooklyn N.J.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Knustwood Mem Park</u>		23d. LOCATION (City, town or county) (State) <u>Alton N.J.</u>	
24. FUNERAL DIRECTOR <u>Birmingham, Ala. House of Hope, Md</u>				25a. REC'D BY REGISTRAR <u>APR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06707

FOR STATE  
HEALTH DEPT

1 PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DARLINGTON</b>		c. LENGTH OF STAY in lb <b>Darlington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <b>EVELYN</b>		4 DATE OF DEATH Month <b>3</b> Day <b>6</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Colored</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>MAY 14 1941</b>
9 AGE (In years last birthday) <b>25 1/2</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY <b>Dom</b>		11 BIRTHPLACE (State or foreign country)	
12 CITIZEN OF WHAT COUNTRY?		13 FATHER'S NAME <b>John HAKINS</b>	
14. MOTHER'S MAIDEN NAME <b>Hattie RUMSEY</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT <b>Evelyn Williams</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Skeletal remains - undetermined cause of death</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Unknown</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Unknown 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Unknown</b>	20f. (City or town) (County) (State) <b>Unknown</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		22. DATE SIGNED <b>3-6-67</b>	
EXAMINER'S NAME (Type) <b>WERNER U. SPITZ, M.D.</b>		23a. RECORD BY REGISTRAR <b>George W Tittle</b>	
23b. DATE THEREOF <b>5-13-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Harford Md</b>	
23d. LOCATION (City or Town) (County) (State) <b>Bel Air Harford Md</b>		23e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>George W Tittle</b>		DATE <b>MAY 22 1967</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03660

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03654

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u> 12.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Craig Street</u>		d. STREET ADDRESS <u>Craig Street</u>	
3. NAME OF DECEASED (Type or print) <u>John T. Doxzen</u>		4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/4/91</u>
9. AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Doxzen</u>		14. MOTHER'S MAIDEN NAME <u>Ida McCabe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>  </u>		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>Cecelia Lane 501 Overbrook Rd. Balt. Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> DUE TO <u>Malnutrition</u> DUE TO <u>Insanitation</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, had an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>3-22-67</u>	
Address (Street, city, town or county)		23a. DATE OF DEATH <u>3-22-67</u>	
23b. LOCATION (City or town) (County) (State) <u>Baltimore Co, Md.</u>		23c. LOCATION (City or town) (County) (State) <u>Baltimore Co, Md.</u>	
23d. LOCATION (City or town) (County) (State) <u>Baltimore Co, Md.</u>		23e. LOCATION (City or town) (County) (State) <u>Baltimore Co, Md.</u>	

Wm. Cook-Brooks Inc. 1217 St. Paul St. Balt. Md.

MAR 27 1967

REC'D BY REGISTRAR

REC'D BY REGISTRAR

REC'D BY REGISTRAR



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**FOR STATE  
HEALTH DEPT.**

**03659**

Reg. Dist. No. **03653**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>FOREST HILL</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RT 23 near High Point Rd</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution's Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EMMORTON</u> d. STREET ADDRESS <u>WHEEL Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MACK</u> Middle <u>DOWELL</u> Last <b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>APRIL 10, 1902</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (in years last birthday) <u>64</u> yrs <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>General Laborer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>CONSTRUCTION</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>NORTH CAROLINA</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>13</u> Year <u>1967</u> <b>13. FATHER'S NAME</b> <u>UNKNOWN</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>DANE DOWELL</u> Address <u>RD #1, Box 255 ABERDEEN, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8124 FRACTURE SKULL - BRAIN PROTRUDING</u> DUE TO <u>MULTIPLE FRACTURES - RT CHEST, LT ARM,</u> (b) <u>BOTH LEGS.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO <u>AUTO - PEDESTRIAN ACCIDENT</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) _____ INTERVA. BETWEEN ONSET AND DEATH _____			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>WALKING CENTER RT 23 IN FOG - STRUCK BY CAR</u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>8:00 p.m. MARCH 13, 1967</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>RT 23</u> <b>20f. (City or town)</b> <u>FOREST HILL</u> <b>(County)</b> <u>HARFORD, Md</u> <b>(State)</b> _____			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></b> <b>ACTUAL SIGNATURE</b> <u>Philip W. Heuman</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>MARCH 13, 1967</u> <b>EXAMINER'S NAME (Type)</b> <u>PHILIP W. HEUMAN, M.D.</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <u>307 HICKORY AVE.</u> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>BEL AIR, Md.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u> <b>22b. DATE THEREOF</b> <u>3/14/1967</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Whitehead Cemetery</u> <b>22d. LOCATION</b> (City, town, or county) <u>Whitehead, North Carolina</u> <b>(State)</b> _____		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tarring Funeral</u> <b>24a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u> <u>Home, Aberdeen, Md.</u> <b>MAR 16 1967</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03661

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03655

1 PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>				c. LENGTH OF STAY IN It <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>				d. STREET ADDRESS <b>310 Wilson Street</b>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>DONALD JOSEPH ETHREDGE</b>				4 DATE OF DEATH Month Day Year <b>March 30 19 67</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Sept. 25, 1933</b>	
9 AGE (In years lost birthday) <b>33</b> yrs		10 IF UNDER 1 YEAR Months Days		11 IF UNDER 24 HRS. Hours Min		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHEMICAL LABORATORY</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HUBERS</b>			
11 BIRTHPLACE (State or foreign country) <b>PA. PHILA.</b>				12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13 FATHER'S NAME <b>CECIL B. ETHREDGE</b>				14 MOTHER'S M.A.DEN NAME <b>MARY MARGARET HOFF</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 1952-1954</b>				16 SOCIAL SECURITY NO. <b>147-24-7382</b>			
17 INFORMANT <b>ELSIE L. ETHREDGE</b>				18 ADDRESS <b>310 WILSON ST. HAVRE-DE-GRACE, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 971.8 IMMEDIATE CAUSE (a) <b>Cyanide Intoxication.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COMOT ON GIVEN IN PART I (a) _____ 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Ingestion of cyanide.</b>			
20c. TIME OF INJURY Month Day Year Hour a.m. <b>XXX 3/ 30 19 67</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.) <b>Factory</b>	
20f. (City or town) (County) (State) <b>Havre de Grace Harford Md</b>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D.				22. DATE SIGNED <b>3/30/67</b>			
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>				Address (Street, city, town, or county) <b>Harford Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>BURIAL</b>		<b>APR. 4, 1967</b>		<b>ODD FELLOW'S CEM.</b>		<b>MILFORD DEL.</b>	
24. FUNERAL DIRECTOR <b>R. Madison Mitchell</b>				25a. REC'D BY REGISTRAR <b>APR 4 1967</b>			
Address <b>Havre de Grace, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03662					03656				
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUKE de GRACE</u>			c. LENGTH OF STAY IN 1b <u>16 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUKE de GRACE</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>					d. STREET ADDRESS <u>421 ST. John ST</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>Peter</u> Last <u>FRITSCH</u>					4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1967</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 28 - 1907</u>		9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clunker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>clunker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HERMAN</u>			14. MOTHER'S MAIDEN NAME <u>Fritsche</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW 2</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>unk</u>			17. INFORMANT <u>Naomi R Fritsche</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> <u>HTX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Decompensation</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 19 <u>66</u> to <u>3-7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-7</u> , 19 <u>67</u> , and that death occurred at <u>4:45</u> P.M. from the causes and on the date stated above.		
22a. SIGNATURE <u>Mont D. Hy</u>			22b. DATE SIGNED <u>3/7/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Mont D. Hy</u>		22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. (BURIAL, CREMATION, REMOVAL) (Specify) <u>3/11/67</u>			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Harford Mem. Garden</u>		23d. LOCATION (City, town or county) (State) <u>Udine Md</u>		
24. FUNERAL DIRECTOR <u>Funeraria Inc. HAUKE de GRACE Md</u>			25a. REC'D BY REGISTRAR DATE <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				





03663

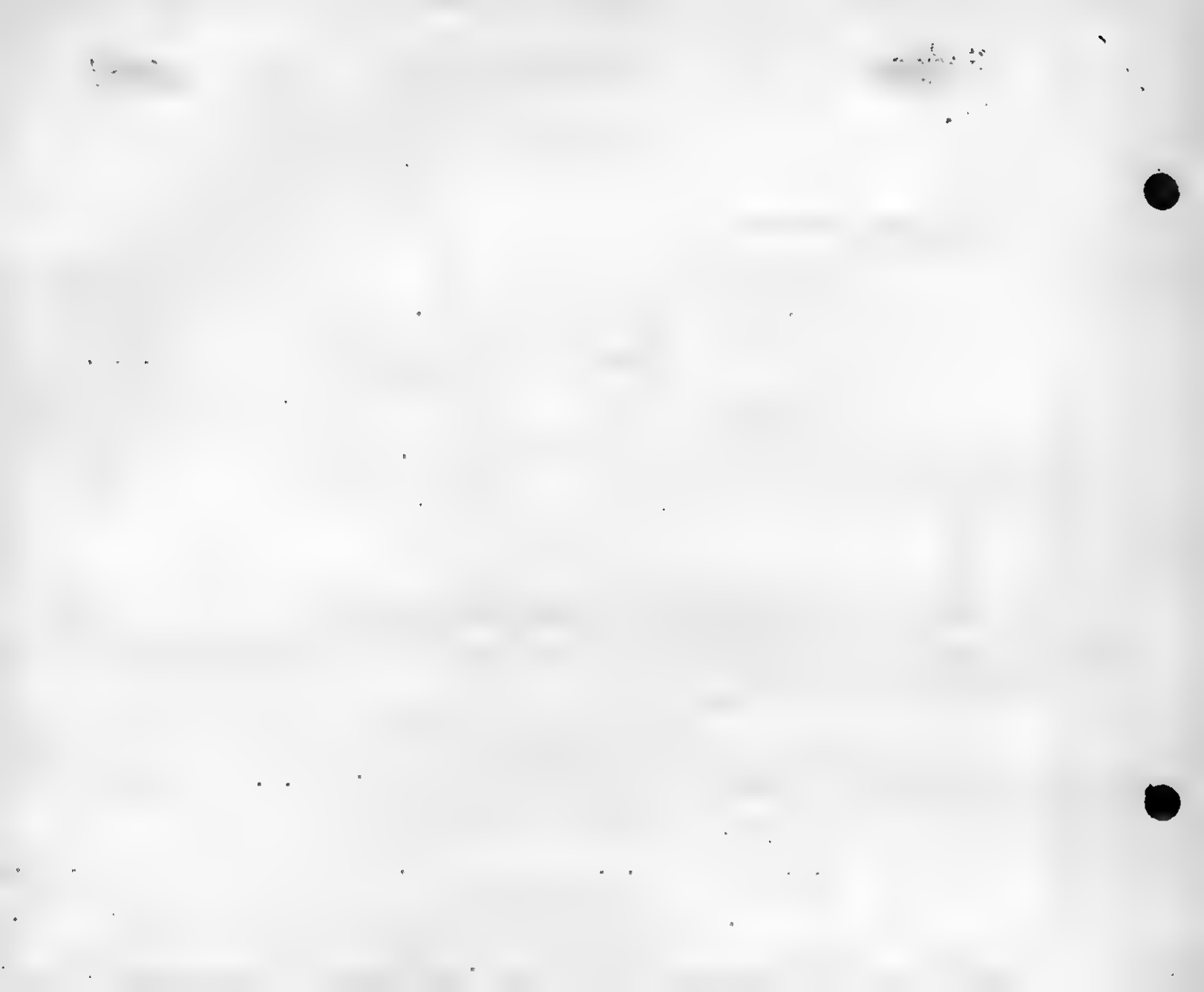
## CERTIFICATE OF DEATH

03657

1 PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c LENGTH OF STAY IN lb <b>Aberdeen</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Citizens Nursing Home</b>		d STREET ADDRESS <b>520 Windemere Drive</b>	
3 NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>CHAPMAN</b> Last <b>GALLION</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Cauc.</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>17 Jan. 1879</b>
9. AGE (In years last birthday) <b>88 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Henry Harward</b>		14. MOTHER'S MAIDEN NAME <b>Sidney Caroline Norris</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>220-20-7909</b>	
17. INFORMANT <b>Edith L. Coen,</b>		Address <b>Same as 2 C &amp; D</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: <b>221X</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Hypertension - Arterio Sclerosis</b> DUE TO (c) <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/10</b> , 19 <b>67</b> , to <b>3/10</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/10</b> , 19 <b>67</b> , and that death occurred at <b>2:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A.L. Lewis</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A.L. Lewis, M.D.</b>		22d. ADDRESS <b>214 N. Union, Havre de Grace, Md.</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>13 Mar. 67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Cokesbury Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Abingdon, Harford Md.</b>	
24. FUNERAL DIRECTOR <b>John E. Tarring</b>		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any information is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03664

03658

1. PLACE OF DEATH  
a. COUNTY

HARFORD

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Havre de Grace Md.

c. LENGTH OF STAY IN b

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)

a. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Pisgah,

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☐

dca Harford Mem. Hospital

3. NAME OF DECEASED  
(Type or print)

JOSEPH

E

GANT

5. SEX

Male

Negro

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

5-14-24

9. AGE (in years last birthday)

42 yrs.

IF UNDER 1 YEAR

31

19 67

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pisgah, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES GANT

(D)

CATHERINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes

WWII

535-26-8356

VA Hospital Records, Perry Point, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Multiple Injuries

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Jumped off ~~XXXXXX~~ Bridge

20c. TIME OF INJURY Month, Day Year

Hour a.m. 1 p.m.

3-31-19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)

X Susquehanna River Havre de Grace, Harford, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspect on ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Gerald C. Palmer

CHIEF MEDICAL EXAMINER Bal Air, Md.

ASS STANT MEDICAL EXAMINER

DATE SIGNED

4-1-67

EXAMINER'S NAME (Type)

GERALD C. PALMER, M.D.

DEPUTY MEDICAL EXAMINER

Address Street city, town, or county

22d. LOCATION (City, town, or country) (State)

22b. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4-5-1967

22c. NAME OF CEMETERY OR CREMATORY

Baltimore National

Baltimore, Md.

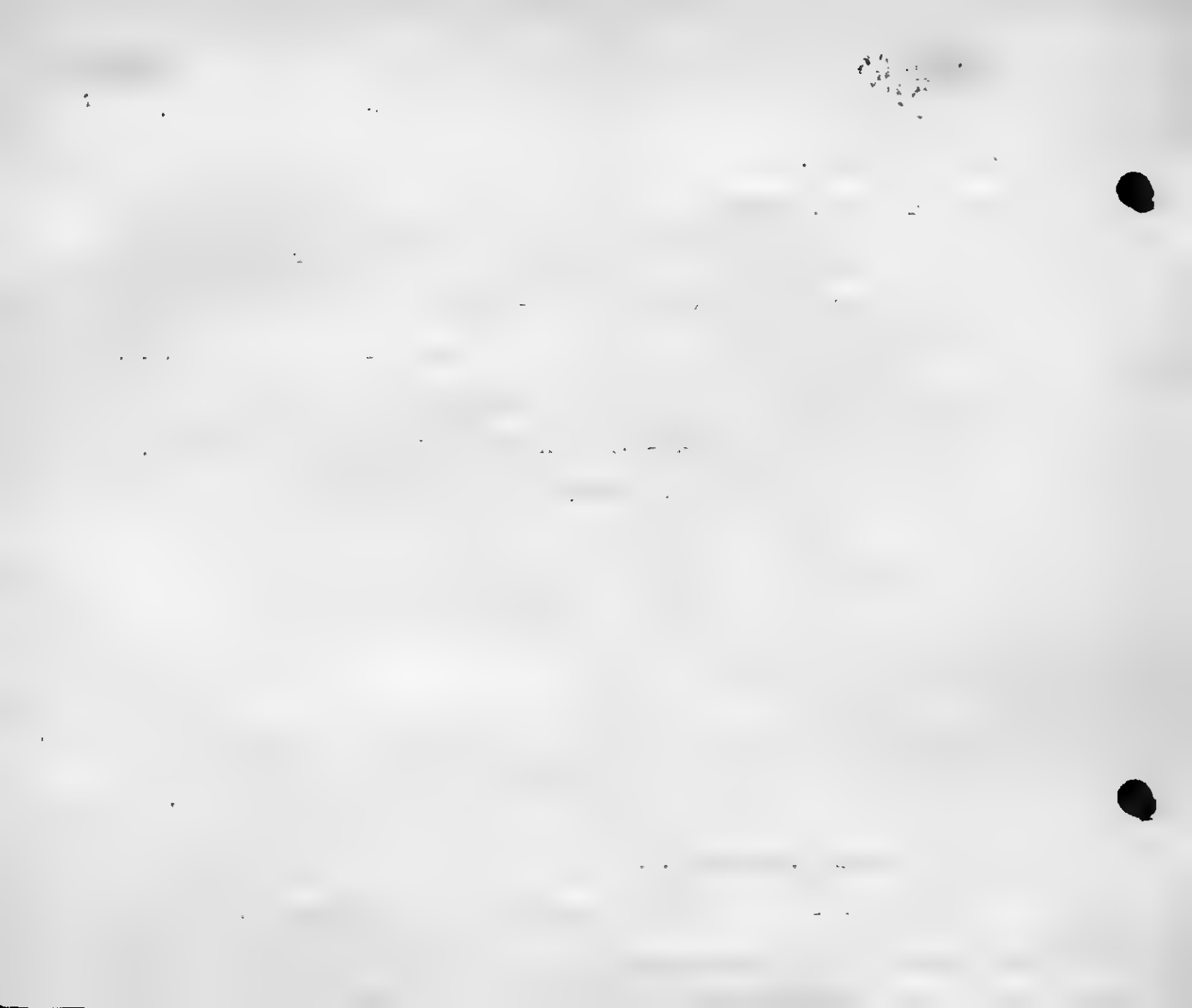
23. FUNERAL DIRECTOR

Lee Patterson & Son Perryville, Md.

24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

APR 5 1967

Charles Judge



03665

## CERTIFICATE OF DEATH

03659

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY- IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial</u>		d. STREET ADDRESS <u>370 South Union Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Francis Joseph Garrabao</u>		4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUL 8, 1992</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Francis Garrabao</u>		14. MOTHER'S MAIDEN NAME <u>Mary Tiernan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>202-09-6341</u>	
17. INFORMANT <u>Mrs. J.C. Lippert</u>		18. ADDRESS <u>7165 Washington St. HAVRE DE GRACE MD. 21078</u>	
1B CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac DeCompensation</u> DUE TO (b) <u>A.S.E.V.I.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) _____	
20c. TIME OF INJURY Month, Day Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> , 19 <u>67</u> , to <u>3/23</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3/23</u> , 19 <u>67</u> and that death occurred at <u>4:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edmond C. Lee, M.D.</u>		22b. DATE SIGNED <u>3/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edmond C. Lee, M.D.</u>		22d. ADDRESS <u>Havre de Grace, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAR. 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Erin Cem.</u>	23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <u>HAVRE DE GRACE, HARTFORD MD.</u>
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>		25a. REC'D BY REGISTRAR <u>MAR 28 1967</u>	
ADDRESS <u>Havre de Grace, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03666

CERTIFICATE OF DEATH

03666

1 PLACE OF DEATH a COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution required before admission) a STATE <u>Maryland</u> b COUNTY <u>Harford</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c LENGTH OF STAY IN 1b <u>26 S. Main Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>26 S. Main Street</u>		d STREET ADDRESS <u>26 S. Main Street</u>	
3 NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Getz</u> Last <u>Getz</u>		4 DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 14, 1895</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Solomon Getz</u>		14. MOTHER'S MAIDEN NAME <u>Mary ?</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W. W. 1</u>		16. SOCIAL SECURITY NO <u>218-32-2063</u>	
17 INFORMANT <u>Mrs. Tillye Getz, 26 S. Main Street</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 CARDIAC ARREST DUE TO</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CARDIO VASC. DISEASE</u> (c) <u>20 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>IMMED</u> <u>MINUTES</u> <u>20 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>APR 1953</u> to <u>31 MAR 1967</u> , that (I) (we) last saw the deceased alive on <u>SPRING 1966</u> , and that death occurred at <u>2A</u> M, from causes on and on the date stated above			
22a. SIGNATURE <u>H. P. Sidwell M.D.</u>		22b. DATE SIGNED <u>3/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. H. P. Sidwell</u>		22d. ADDRESS <u>401 Franklin St., Bel Air, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bnai Israel</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>APR 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

200





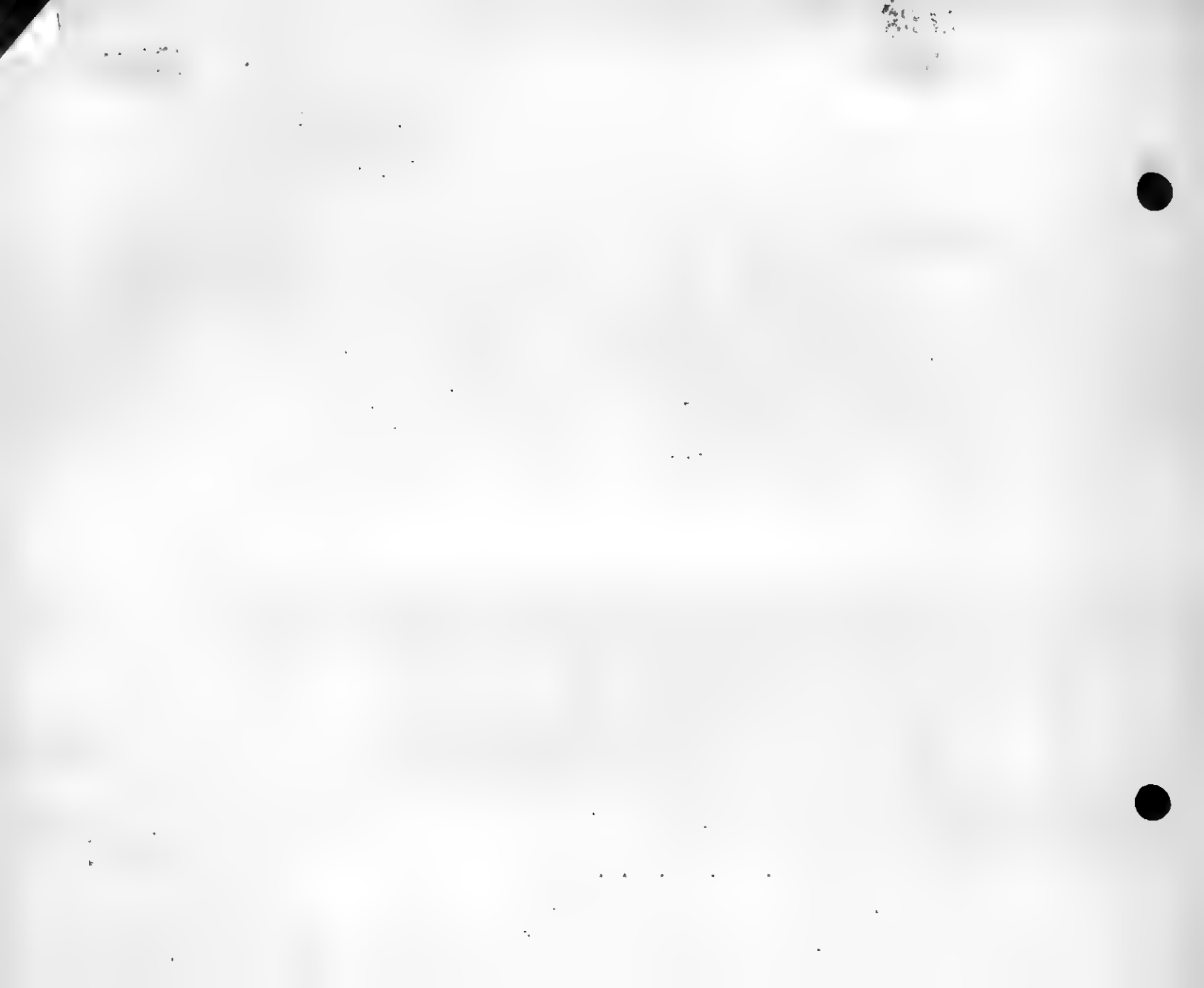
FOR STATE  
HEALTH DEPT.

TO DEPUTY MED. EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISWE (5)  
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03667		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						03661	
1. PLACE OF DEATH a. COUNTY <b>Harford</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Darlington</b>			c. LENGTH OF STAY IN ID <b>Lifetime</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Darlington</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Route 1</b>					d. STREET ADDRESS <b>Route 1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Herbert W. Gittings</b>			First Middle Last		4. DATE OF DEATH <b>March 6 19 67</b>		Month Day Year		
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>Dec. 12, 1900</b>		9. AGE (In years last birthday) <b>66 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rotor Keesee</b>		11. BIRTHPLACE (State or foreign country) <b>Harford County, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>William Gittings</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Smith</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-12-4608A</b>		17. INFORMANT <b>Ms. Beulah M. Smith</b>			Address <b>Rt 2 Box 357 Street, Md. 21154</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH _____ _____ _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								22. DATE SIGNED <b>March 7, 1967</b>	
ACTUAL SIGNATURE <b>Gerald C. Palmer</b>				EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>			22. DATE SIGNED <b>March 7, 1967</b> Bel Air, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 11, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Charles Chapel Met. Am.</b>			23d. LOCATION (City, town or county) (State) <b>Bel Air, Harford Co. Md.</b>		
24. FUNERAL DIRECTOR <b>Charles J. Bullock, House of Free Md. 21075</b>				ADDRESS <b>556 E. 1st St</b>		25a. REC'D BY REGISTRAR <b>MAR 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

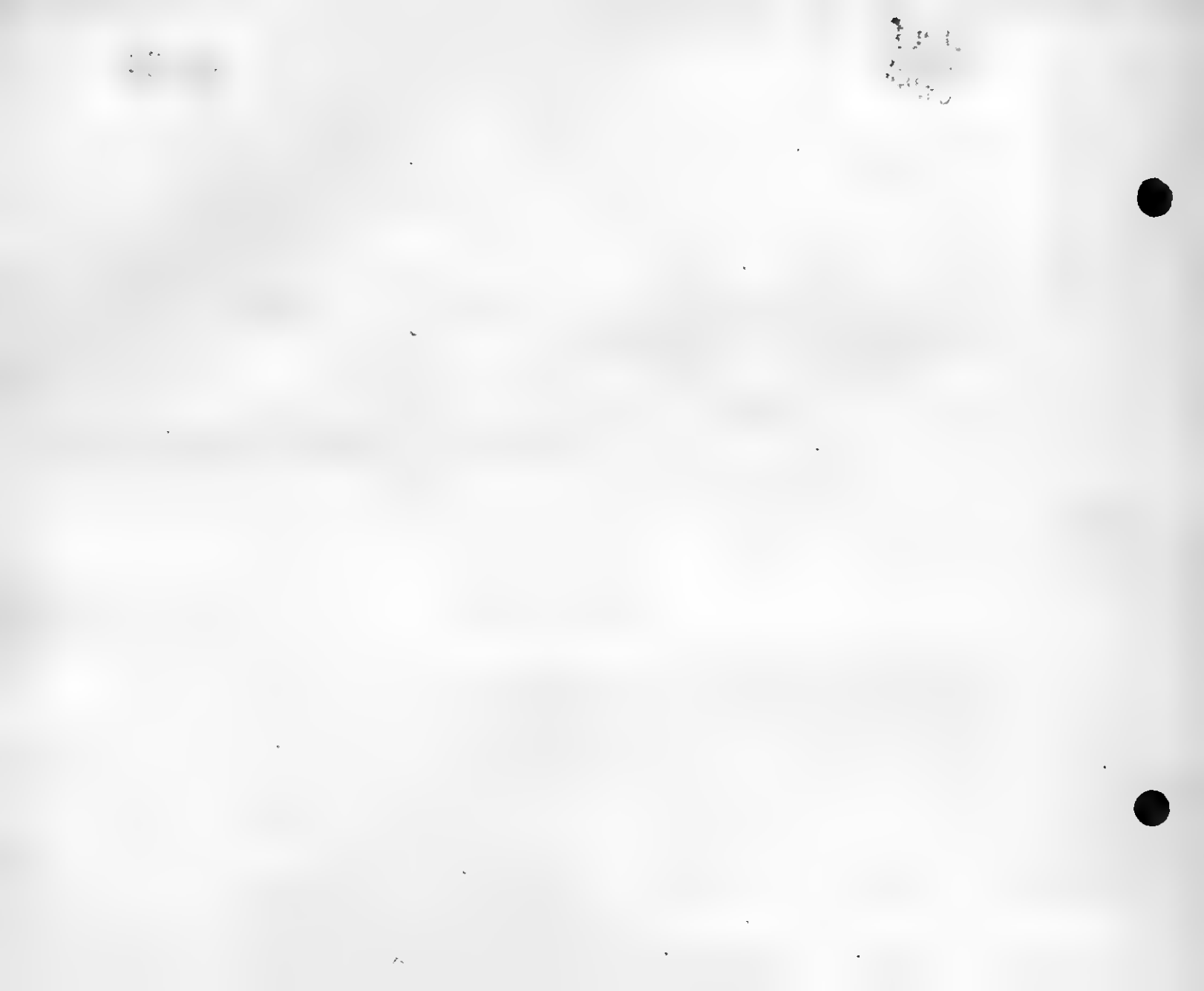


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03668						03662					
1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-frace</u>				c. LENGTH OF STAY In 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> 12-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>						d. STREET ADDRESS <u>1306 Moore's Mill Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Am brose</u> First <u>Greer</u> Middle Last		4. DATE OF DEATH <u>3</u> Month <u>11</u> Day <u>1967</u> Year		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 24, 1894</u>	
9. AGE (In years last birthday) <u>72</u> yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Greer</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Taylor</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>230 10-2583</u>		17. INFORMANT (Name) <u>Mrs. Hattie J. Greer</u> Address <u>1306 Moore's Mill Rd. Bel Air, Maryland 21014</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart Diabetes mellitus</u> DUE TO (c) <u>and Arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>67</u> , to <u>3-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Judley Phillips MD</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/12/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Judley Phillips MD</u>						22d. ADDRESS <u>DARlington and 2103</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>March 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air, Hartford Co., Maryland 21014</u>			
24. FUNERAL DIRECTOR <u>W. Broadway &amp; Williams St</u> <u>Joseph William Foster</u> <u>Bel Air, Maryland 21014</u>						25a. REC'D BY REGISTRAR <u>MAR 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 4-64

<div style="display: flex; justify-content: space-between;"> <div> <p>4</p> <p>1</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>03669</p> </div> <div> <p>CERTIFICATE OF DEATH</p> <p>03663</p> </div> </div>										
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>			c. LENGTH OF STAY IN 1b <u>38 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hospital</u>					d. STREET ADDRESS <u>2706 Emmorton Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Frieda</u> Middle <u>B</u> Last <u>HELF</u>					4. DATE OF DEATH Month <u>MARCH</u> Day <u>5</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 29, 1900</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Microfilm Helper Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. - Ret.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York City, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Charles Becker</u>					14. MOTHER'S MAIDEN NAME <u>Anna Kempter</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>214-20-0116</u>		17. INFORMANT <u>Mrs. Dorothy A. Cullum, 2706 Emmorton Road</u>				Address <u>Abingdon, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). 1. PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> DUE TO (b) <u>Cerebral Vascular Hemorrhage</u> DUE TO (c) <u>A.C.V.D. and H.C.V.D.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>&gt; 1 year</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-27, 1967</u> to <u>3-5, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 5 1967</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Edward C. Lee, M.D.</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/5/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>					22d. ADDRESS <u>Harre de Grace, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Lutheran Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Perry Hall Balto Md</u>			
24. FUNERAL DIRECTOR <u>Howard K. McComas &amp; Son, Abingdon, Md. 21009</u>					25a. REC'D BY REGISTRAR <u>MAR 7 1967</u>					
					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

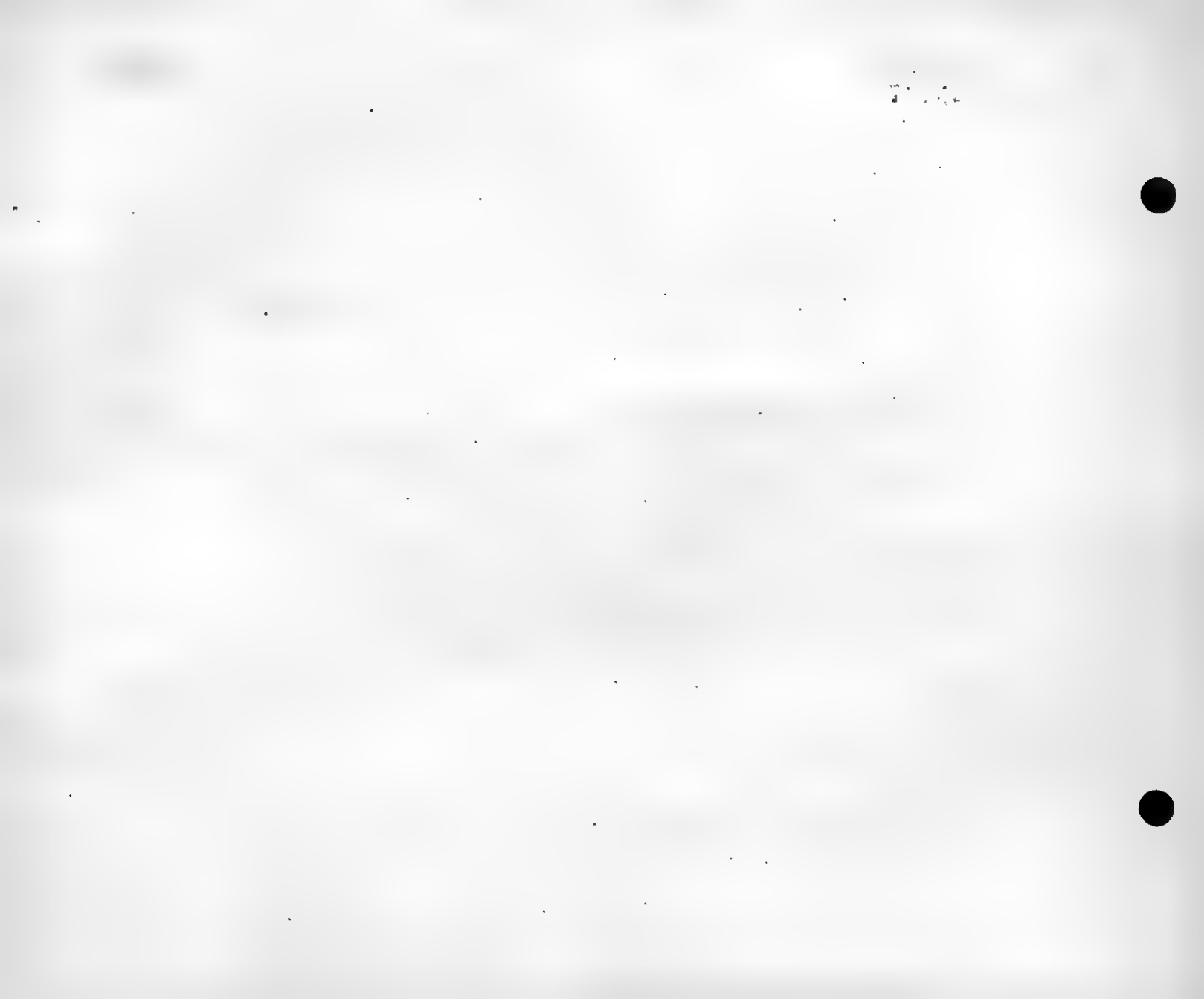
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03670

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03664

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>		c. LENGTH OF STAY in 1b <u>Since 1944</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>134 Archer Street</u>				d. STREET ADDRESS <u>134 Archer Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>B.</u> Last <u>Hickman</u>				4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14, 1921</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Harrisburgh, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jake W. Boyden</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Gamble</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>227-18-4559</u>		17. INFORMANT Address <u>134 Archer St.</u> <u>Mr. Louis A. Hickman, Belt Air, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Third Degree Burns Face</u> <u>9160</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in house fire</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>1030</u> p.m. <u>3-10</u> 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Belt Air, Harford Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				22. DATE SIGNED <u>3-11-67</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>				Address (Street, city, town, or county) <u>  </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Burkley Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Carlington, Harford Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Charles J. Bullock, Harford Co. Md 21078</u>				25a. REC'D BY REGISTRAR MAR 14 1967 DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03671

CERTIFICATE OF DEATH

03665

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DeGRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Hanford Memorial Hospital</u>		d. STREET ADDRESS <u>Theodore Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Cullens</u> Last <u>Hudson</u>		4 DATE OF DEATH Month <u>MAR</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Can.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-22-1905</u>
9 AGE (In years last birthday) <u>61</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>labor</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>George Hudson</u>	
14. MOTHER'S MAIDEN NAME <u>SARA</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO. <u>185-09-4725</u>		17. INFORMANT <u>S. Elizabeth Hudson, Rising Sun, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> (c) <u>Arterio Sclerosis</u>		INTERVA. BETWEEN ONSET AND DEATH <u>6 mos</u> <u>6 months</u> <u>3 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 25, 1966</u> to <u>March 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 20, 1967</u> , and that death occurred at <u>11:50</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Clarence I. Benson</u> M.D.		22b. DATE SIGNED <u>Feb 21-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>CLARENCE I. BENSON</u>		22d. ADDRESS <u>Port Deposit, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-24-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, Md.</u>	
24 FUNERAL DIRECTOR <u>Lee G. Patterson, Jr., Perryville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03672

CERTIFICATE OF DEATH

03666

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAURE de GRACE</i>		c. LENGTH OF STAY IN 1b <i>24 hrs.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		d. STREET ADDRESS <i>538 So. Phila. Blvd.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>EMMA</i> Middle <i>LOUISA</i> Last <i>JAMES</i>		4. DATE OF DEATH Month <i>MARCH</i> Day <i>1</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>16 Aug. 1883</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	9. AGE (In years last birthday) <i>83</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <i>Abingdon, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James B. Leight</i>		14. MOTHER'S MAIDEN NAME <i>Alice Mouldsdales</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-52-7199</i>	17. INFORMANT <i>Naomi, James</i> Address <i>Aberdeen, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> <i>159X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>gastrointestinal malignancy</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>generalized arteriosclerosis: ASCVD</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 Hour</i> <i>~ 3 mos.</i>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 28</i> , 1967, to <i>March 1</i> , 1967, that (I) (we) last saw the deceased alive on <i>MARCH 1</i> , 1967, and that death occurred at <i>2:45 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>B.J. Plunkett Jr.</i>		22b. DATE SIGNED <i>3-1-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>B.J. Plunkett Jr. M.D.</i>		22d. ADDRESS <i>W. Bel Air Avenue Aberdeen, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4 Mar. 67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cokesbury Memorial Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Abingdon, Maryland</i>
24. FUNERAL DIRECTOR <i>John L. Tarrington</i>		25a. REC'D BY REGISTRAR <i>John L. Tarrington</i>	
25b. REGISTRAR'S SIGNATURE <i>John L. Tarrington</i>		DATE <i>MAR 3 1967</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03673						03667					
1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Stavre de Grace</i>				c. LENGTH OF STAY IN 1b <i>Lifetime</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Stavre de Grace</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>837 Erie Street</i>						d. STREET ADDRESS <i>837 Erie Street</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>E.</i> Last <i>Johnson</i>						4. DATE OF DEATH Month <i>March</i> Day <i>3</i> Year <i>1967</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 1883</i>		9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Perryman, Harford Co. Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Isaac Dennison</i>						14. MOTHER'S MAIDEN NAME <i>Annie Webster</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Robert B. Johnson, Stavre de Grace, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Hypertensive-Arteriosclerotic Heart disease</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>9/18</i> , 19 <i>54</i> , to <i>3/3</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/1</i> , 19 <i>67</i> , and that death occurred at <i>6:00</i> A.M., from the causes and on the date stated above.											
22a. SIGNATURE <i>George T. Stansbury</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>3/4/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>						22d. ADDRESS <i>569 Revolution St. Havre de Grace, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 7, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>			23d. LOCATION (City, town or county) (State) <i>Aberdeen, Harford Co. Md.</i>				
24. FUNERAL DIRECTOR <i>Etelia L. Bullock, Havre de Grace, Md.</i>						25a. REC'D BY REGISTRAR <i>MAR 9 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03674

CERTIFICATE OF DEATH

03668

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Pylesville</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS  b. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>F.</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1876</u>
9 AGE (In years last birthday) yrs. <u>91</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Greasy Creek, N.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas D. Jones</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Pugh</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>219-36-0102A</u>		17. INFORMANT <u>John Paul Jones, Forest Hill, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic Cerebro Vascular Disease</u> DUE TO (c) <u>Chronic Arteriosclerotic Cardiovascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a), <u>Chronic Uremia (in remission)</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>42</u> , to <u>March 19</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 18</u> 19 <u>67</u> , and that death occurred at <u>2:45</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Willard P. Hudson</u> M.D.		22b. DATE SIGNED <u>Mar. 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard P. Hudson</u>		22d. ADDRESS <u>H.I. Forest Hill, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar. 22, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland</u>	23d. LOCATION (City or Town) (County) (State) <u>Street, Harford Co., Md.</u>
24. FUNERAL DIRECTOR <u>John H. Harkins</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
GM 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03675

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03669

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>10 YEARS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>202 Penn Ave</u>		e. STREET ADDRESS <u>202 Penn Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Octavia Adele Keebler</u>		4 DATE OF DEATH <u>Feb March 9 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 1, 1898</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
10. BIRTHPLACE (State or foreign country) <u>Charleston, S.C.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
12. FATHER'S NAME <u>William Edward Howell</u>		13. MOTHER'S MAIDEN NAME <u>Adele Aymar</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		15. SOCIAL SECURITY NO <u>212-50-3257</u>	
16. INFORMANT (Daughter) <u>734-6443</u> Address <u>Box #1, Box #385 Bel Air, Maryland 21014</u>		17. Mrs. Jacqueline H. Miller	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> 4081 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, b.d.g., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> injury <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u> 22. DATE SIGNED <u>3-9-67</u>	
EXAMINER'S NAME (Type) <u>Gerald P Palmer - MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Harford Co., Md. 21014</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REG STRAR <u>MAR 13 1967</u>	
ADDRESS <u>40 Broadway &amp; Williams Bel Air, Maryland 21014</u>		25b. REG STRAR'S SIGNATURE <u>Charles Judge</u>	



03676

## CERTIFICATE OF DEATH

03676

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Street</u>		c. LENGTH OF STAY IN lb <u>8</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>C.</u> Last <u>Laird</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 16, 1933</u>
9. AGE (In years, last birthday) <u>34</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Livestock Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugh M. Laird</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Boyd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-40-0285</u>	
17. INFORMANT <u>Mrs. Florence F. Laird</u>		Address <u>Street, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis - massive</u> DUE TO (b) <u>Advanced arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>25 Mar</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>25 Mar</u> , 19 <u>67</u> , and that death occurred at <u>4:35 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Edwin W. Whiteford, Jr. M.D.</u>		22b. DATE SIGNED <u>3/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edwin W. Whiteford, Jr. M.D.</u>		22d. ADDRESS <u>Whiteford, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmory Church Cemetery, Harford Co., Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>John H. Harding</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		25c. REC'D BY REGISTRAR <u>MAR 30 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove support papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #3 Film #0387 3/23/67 PC

03677

CERTIFICATE OF DEATH

03671

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUKES GRACE</u>		c. LENGTH OF STAY IN 1b <u>2 MINUTES</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>HAUKES GRACE</del> <u>Joppatowne</u>		d. STREET ADDRESS <u>303 Barksdale Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Baby Boy</u> Last <u>McCoy</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-67</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert McCoy</u>		14. MOTHER'S MAIDEN NAME <u>Mary Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Robert McCoy</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrauterine Asphyxia</u> DUE TO <u>7543</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital Heart Disease</u> DUE TO (c) <u>intra cranial hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-15-1967</u> , to <u>7:41 AM</u> , that (I) (we) last saw the deceased alive on <u>3-15-1967</u> , and that death occurred at <u>7:41 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John C. Ruck</u> M.D.		22b. DATE SIGNED <u>3/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harford Memorial Hospital</u>		22d. ADDRESS <u>Harford Memorial Hospital</u>	
23a. BURIAL, CREMATION, REMAINS (Specify)	23b. DATE THEREOF <u>3/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beverly Hills Men. Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Morgantown, W. Va.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>



## CERTIFICATE OF DEATH

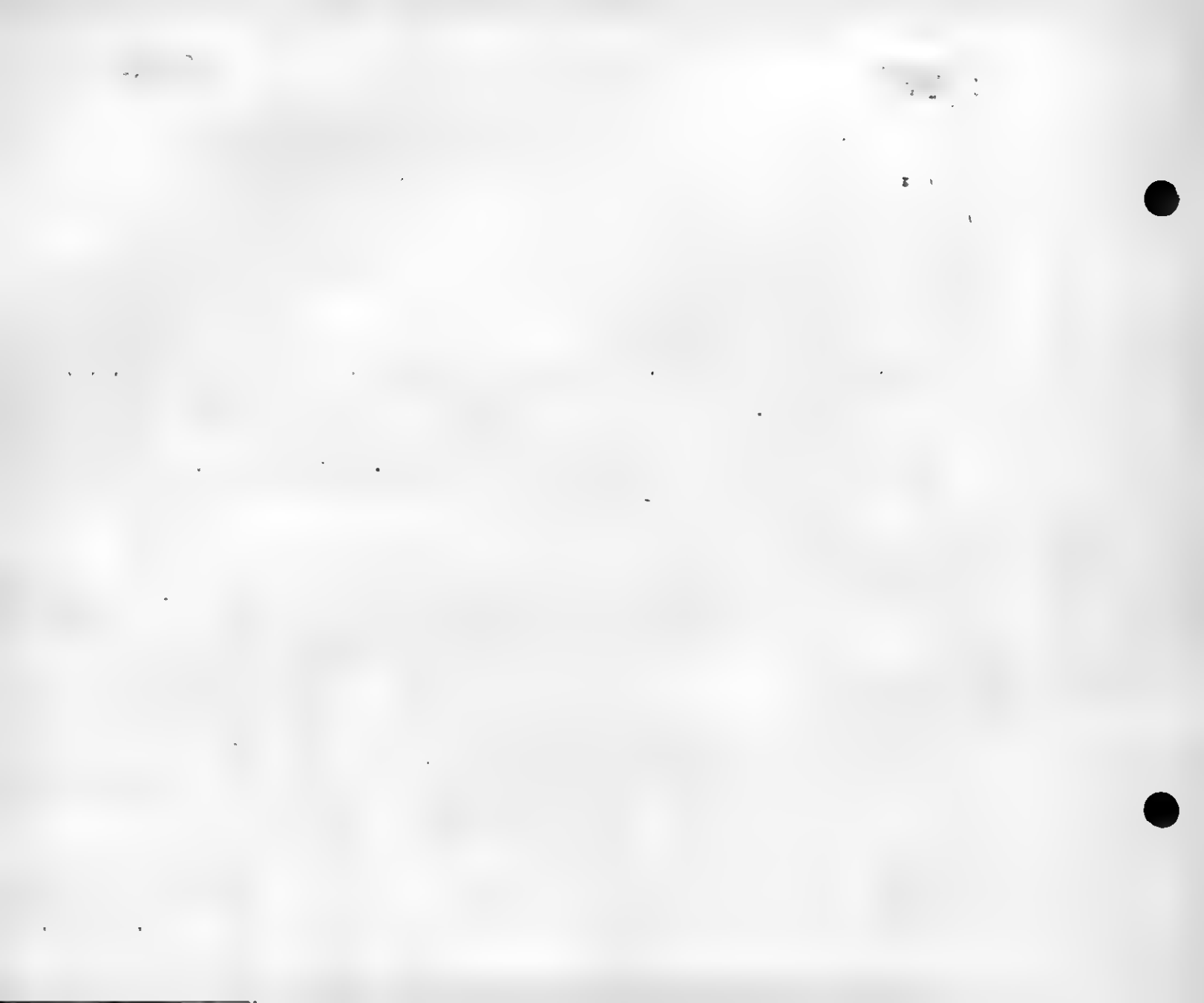
03678

03672

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERLE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worton, Maryland</u>	
c. LENGTH OF STAY IN lb <u>17 days</u>		d. STREET ADDRESS <u>Worton, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Loda Smith Mooney</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-1882</u>
9. AGE (In years last birthday) <u>84 yrs.</u>		10. IF UNDER 1 YEAR Months <u>26</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret. Florist</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James A. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Dwyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-36-8479</u>	
17. INFORMANT <u>Mrs Grace M. Goldman</u>		Address <u>503 #. Lake Avenue #12</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Old age</u> DUE TO (b) <u>A.S.C.V.D</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1966</u> to <u>3/26/67</u> , that (I) (we) last saw the deceased alive on <u>May 26, 1967</u> , and that death occurred at <u>5:55 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Yun</u>		22b. DATE SIGNED <u>AM</u>	
22c. PHYSICIAN'S NAME (Type) <u>John D. Yun</u>		22d. ADDRESS <u>HAVERLE GRACE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-29-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Lessa Funeral Home</u>		25a. REC'D BY REGISTRAR <u>36</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAR 28 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain on carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

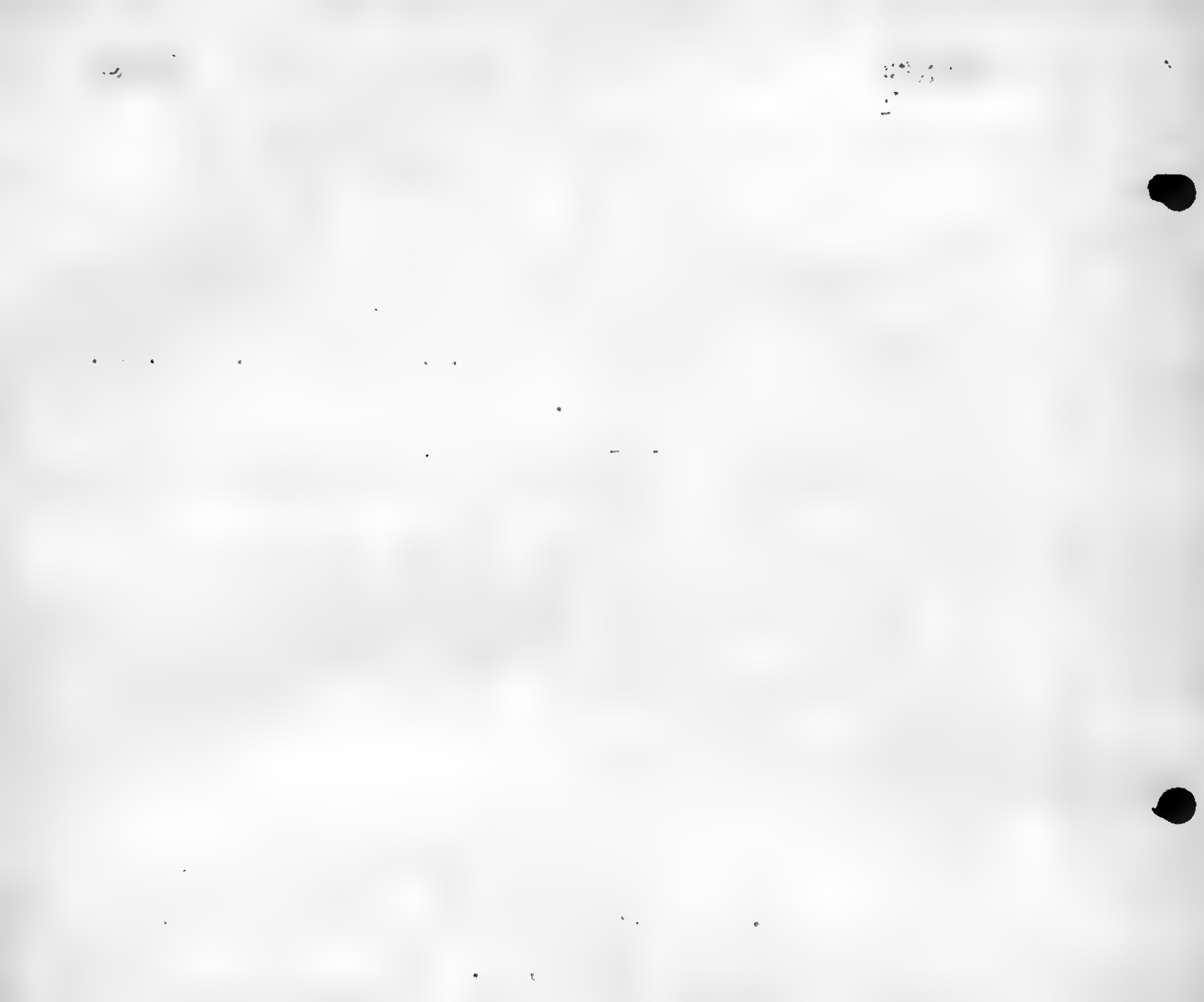
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03673

03673

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parlington</u>	
c. LENGTH OF STAY IN 1b <u>4</u>		d. STREET ADDRESS <u>RD 1 Box 21</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Doa Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carroll Edwin Morrison Jr</u>		4. DATE OF DEATH Month Day Year <u>March 5 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 June 1948</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>R.D. Bel Air, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carroll Edwin Morrison Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Susie Little</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-50-0149</u>	
17. INFORMANT <u>Father, Same as 2 C &amp; D</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiated due to CO</u> 9731 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Piped exhaust fumes into car</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7:55</u> <u>3-5</u> 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Broadway Lane Parlington Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Bernell C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 3-5-65	
EXAMINER'S NAME (Type) <u>Carroll E Palmer</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8 Mar. 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Aberdeen, Maryland</u>	
24. FUNERAL DIRECTOR <u>Webster Macaulay</u>		25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



1

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03680

03674

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>545 Cressy Road</b>				d. STREET ADDRESS <b>545 Cressy Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Virginia Reid Munnikhuyson</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> , Year <b>1967</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 23, 1905</b>	9. AGE (in years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Oays Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harford Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Hall Lee Munnikhuyson</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Reid</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-38-4591</b>		17. INFORMANT (Executor) <b>838-4660</b> <b>Rev. Joseph D. Knisely Abingdon, Md. 21009</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESP. FAILURE</b> DUE TO (b) <b>METASTATIC MALIGNANCY</b> DUE TO (c) <b>SARCOMA PRIMARY IN KNEE (LEFT) @ 2 YRS</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>  <b>1 YR</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>MAR 1951</b> to <b>30 MAR 1967</b> , that (I) (we) last saw the deceased alive on <b>30 MAR 1967</b> , and that death occurred at <b>6:50 PM</b> from the causes and on the date stated above.								
22a. SIGNATURE <i>H. Proctor Sidwell</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 30, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>H. Proctor Sidwell, M.D.</b>				22d. ADDRESS <b>401 Franklin Street, Bel Air, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 3, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Spring Episcopal Cem. Forest Hill, Harf., Md.</b>		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>				25a. REC'D BY REGISTRAR <b>APR 3 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Joseph William Foster



03681

CERTIFICATE OF DEATH

03675

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, if any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>727 Ontario ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>John Sedric NELSON</u>		4. DATE OF DEATH <u>3</u> <u>24</u> <u>19</u> <u>67</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 18-1882</u>
9 AGE (In years last birthday) <u>84</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR IND. <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John August Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Leda Mary Swenson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unk.</u>	
17. INFORMANT <u>Ruth Lunch, same as above</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>pulmonary edema</u> 4221 DUE TO <u>A.S.C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>old age</u> (b) <u>  </u> (c) <u>  </u>			INTERVA. BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-15</u> , 19 <u>67</u> , to <u>3-24</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>3-24</u> 19 <u>67</u> , and that death occurred at <u>2:37 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Yun</u>		22b. DATE SIGNED <u>3/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. YUN</u>		22d. ADDRESS <u>HARRE-DE-GRAVE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ann</u>	23d. LOCATION (City or town) (County) (State) <u>Harre-de-Grace, Md.</u>
24. FUNERAL DIRECTOR <u>Funerary Co. Harre-de-Grace, Md.</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

MAR 28 1967



03682

CERTIFICATE OF DEATH

03676

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Harford</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>		c LENGTH OF STAY IN 1b <b>1 year</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>--</b>				d STREET ADDRESS <b>205 Doncaster Road, Joppa town</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>FREDERICKA</b> Middle <b>--</b> Last <b>OAKLEY</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>27</b> Year <b>1967</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>October 12, 1888</b>		9 AGE (In years last birthday) <b>78 yrs.</b>	10 IF UNDER 1 YEAR Months <b>27</b> Days <b>19</b> Hours <b>67</b> Min.	11 IF UNDER 24 HRS Months <b>27</b> Days <b>19</b> Hours <b>67</b> Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harford Co, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>John Rembold</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Sigmund</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>214-26-4952</b>		17 INFORMANT <b>Elizabeth Mae Lynch, Fallston, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>ASCVD - Coronary Heart Failure</b> DUE TO (b) <b>Coronary Artery Disease, Insufficiency</b> DUE TO (c) <b>Carcinoma of Breast</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/21/67</b> , 19 <b>67</b> to <b>3/27</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/21/67</b> and that death occurred at <b>11 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>E. Louis Kahan</i>				22b. DATE SIGNED <b>3/27/67</b>		22c. PHYSICIAN'S NAME (Type) <b>E. Louis Kahan, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 30, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Cemetery Abingdon, Harford Md</b>	
24 FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md. 21009</b>				25a. REC'D BY REGISTRAR <b>MAR 30 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





03683

CERTIFICATE OF DEATH

03677

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Houma de Grace</u>		c. LENGTH OF STAY IN IB <u>1 Day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural* Street</u>		d. STREET ADDRESS <u>R.D.#2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>B.</u> Last <u>ORR</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1890</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Dublin, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alex R. Lee</u>		14. MOTHER'S MAIDEN NAME <u>Addie M. Swift</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-34-6637</u>	
17. INFORMANT <u>Merton L. Orr, Street, Maryland</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Old Age</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 12, 1950</u> , to <u>MAR 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAR 24, 1967</u> , and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dudley Phillips MD</u>		22b. DATE SIGNED <u>3/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>Darlington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Mar. 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dublin Southern</u>	23d. LOCATION (City or Town) (County) (State) <u>Dublin, Harford Co., Md.</u>
24. FUNERAL DIRECTOR <u>John H. Harkins</u>		25a. REC'D BY REGISTRAR <u>MAR 28 1967</u>	
ADDRESS <u>Delta, Penna.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2010



03684

## CERTIFICATE OF DEATH

03678

1 PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pylesville</b> c. LENGTH OF STAY IN lb <b>Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pylesville</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>JOHN BENJAMIN PICKER</b>		4. DATE OF DEATH <b>March 18, 1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 3, 1908</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUA. OCCUPAT ON (Give kind of work done during most of working life, even if retired) <b>Gov't Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Army Chem. Center Harford Co., Md.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Milton John Picker</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Harrison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>220-20-7568</b>	
17 INFORMANT <b>Mrs. Nettie Picker, Pylesville, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerosis</b> 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) <b>It has been proven Coronary attack</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>5-7 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>1967</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>6P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>William O. Fulton</b>		22b. DATE SIGNED <b>3/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William O. Fulton</b>		22d. ADDRESS <b>Stewartstown, Penna. 17363</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-21-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Meth. Cem. Pylesville, Harford Co., Md</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Benneth W. Chisholm</b>		25a. REC'D BY REGISTRAR <b>Stewartstown, Pa</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and twenty event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03685

03679

1 PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>				c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Aberdeen,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>				d. STREET ADDRESS <b>Route #1, Box 250</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>GILBERT B. QUILLEN</b>				4 DATE OF DEATH <b>March 10 1967</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc.</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>17 June 1910 56</b>	
9 AGE (In years last birthday) <b>56</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		11 BIRTHPLACE (State or foreign country) <b>Rugby, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13 FATHER'S NAME <b>Luther E. Quillen Sr.</b>			
14. MOTHER'S MAIDEN NAME <b>Eula Walton</b>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16 SOCIAL SECURITY NO <b>215-05-1615</b>				17. INFORMANT <b>Lexie Quillen, Aberdeen, Maryland</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <b>11 March 1967</b>				23a. B. J. R. L. CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>13 Mar. 67</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial</b>			
23d. LOCATION (City or Town) (County) (State) <b>Bel Air-Harford Md.</b>				23e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
24. FUNERAL DIRECTOR <b>John E. Tarring</b>				25a. REC'D BY REGISTRAR <b>MAR 13 1967</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03686						03680					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Harford</u> MARYLAND						a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>					
c. LENGTH OF STAY IN 1b <u>17 days</u>						d. STREET ADDRESS <u>RFD #2</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hosp.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First <u>Elmer</u> Middle <u>II</u> Last <u>Randow</u>						Month <u>March</u> Day <u>6</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 3, 1895</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK FOREMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CASTLETON, MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES E. RANDOW</u>						14. MOTHER'S MAIDEN NAME <u>AMANDA RHOADES</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>912-07-5407R</u>		17. INFORMANT <u>MRS. ELMER RANDOW, DARLINGTON, MD.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerotic Cardiovascular Disease</u> (c) <u>Vascular Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>						20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> 19 <u>67</u> , to <u>MARCH 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 6, 1967</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward C. Lee, M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/6/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>						22d. ADDRESS <u>Haure de Grace, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
<u>BURIAL</u>			<u>MAR. 10, 1967</u>		<u>DUBLIN SOUTHERN</u>			<u>DUBLIN, MD.</u>			
24. FUNERAL DIRECTOR <u>John H. Haskins, DELTA, PA.</u>						25a. REC'D BY REGISTRAR <u>MAR 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03688 CERTIFICATE OF DEATH 03682											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Maryland</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u> c. LENGTH OF STAY IN 1b <u>77 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u> d. STREET ADDRESS <u>706 Fountain</u>					
3. NAME OF DECEASED (Type or print) <u>Clifford Santmyer</u> First Middle Last 4. DATE OF DEATH <u>3/18/67</u> 19 <u>19</u> Month Day Year						5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>6/17/89</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Police</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Harford Chase</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>William Santmyer</u> 14. MOTHER'S MAIDEN NAME <u>Lidia Thompson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Home Santmyer</u> Address <u>706 Fountain St. Harford Chase Md.</u>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>16 x 1</u> DUE TO <u>Branchogenic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____											
21. I certify that (I) (this hospital) attended the deceased from <u>4-21</u> to <u>5-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-17</u> , 19 <u>67</u> , and that death occurred at <u>5:45</u> M., from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED <u>3/20/67</u> 22c. PHYSICIAN'S NAME (Type) <u>H. H. H. H.</u> M.D. 22d. ADDRESS _____						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL CREMATION, REMOVAL (Specify) <u>3/21/67</u> 23b. DATE THEREOF <u>William Chapel</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Harford Chase Md.</u> 23d. LOCATION (City, town or county) (State) _____											
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Harford Chase Md.</u> 25a. REC'D BY REGISTRAR <u>MAR 23 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>											



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03689

## CERTIFICATE OF DEATH

03683

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution on. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLSTON</u>		c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLSTON</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 88 Zone 21047</u>			d. STREET ADDRESS <u>Box 88 Zone 21047</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ERNEST L Seawell</u>			4. DATE OF DEATH <u>MAR 18 1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 21, 1905</u>		9. AGE (In years last birthday) <u>61</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VA</u>	
13. FATHER'S NAME <u>JCHN SEAWELL</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO <u>213-07-9870</u>		17. INFORMANT <u>TRENT SEAWELL</u> Address <u>5531 W. H. 17th Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumococcal Carcinoma - Metastasis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE <u>Kermit P. Bonovich</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>KERMIT P. BONOVICH, M.D.</u>		22d. ADDRESS <u>2300 Bel Air Rd. Fallston 21047</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>MAR 21 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCDON PARK</u>		23d. LOCATION (City or town) (County) (State) <u>BALTIMORE MD.</u>	
24. FUNERAL DIRECTOR <u>J. E. CONNELLY SONS</u>		ADDRESS <u>300 MACE</u>		25a. REC'D BY REGISTRAR <u>MAR 21 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



03690

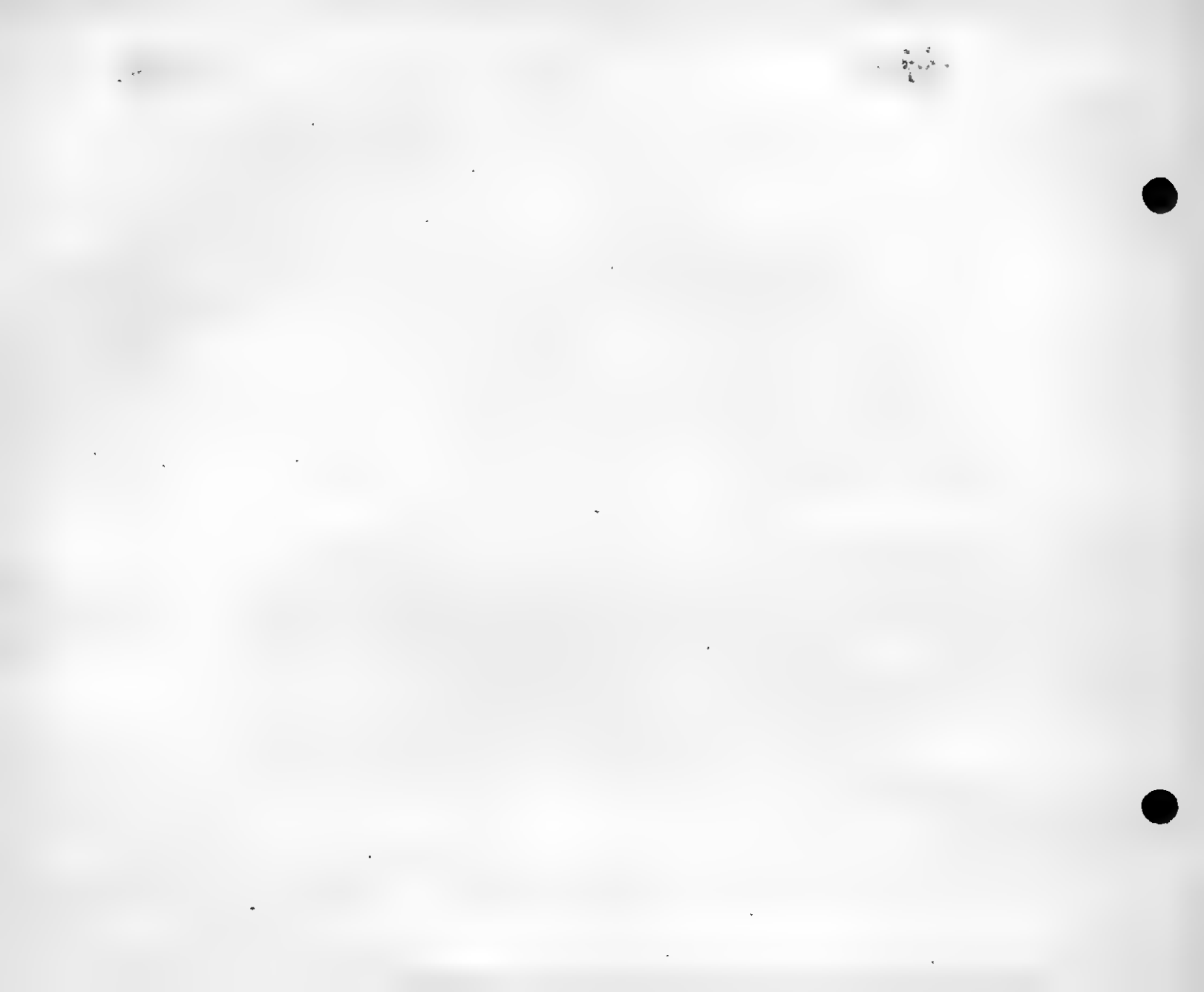
## CERTIFICATE OF DEATH

03684

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSP.</u>				d. STREET ADDRESS <u>613 GREENE ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>ELIAS</u> Last <u>SHEAFFER</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 16, 1903</u>	
9. AGE (In years last birthday) <u>64</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOP - Lumber Yard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOSHUA E. SHEAFFER</u>			
14. MOTHER'S MAIDEN NAME <u>SUSIE C. WELDON</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO <u>217-12-8352</u>				17. INFORMANT <u>M. EDNA H. SHEAFFER, HARVE DE GRACE MD.</u>			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Anterior &amp; Posterior coronary occlusion</u> DUE TO (c) <u>ABCD &amp; shock (thrombi)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Papercation rectosigmoid colon</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1967</u> to <u>March 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 16, 1967</u> , and that death occurred at <u>7:55</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>A.W. GRIGOLEIT</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.W. GRIGOLEIT</u>				22d. ADDRESS <u>HARVE DE GRACE</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR. 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SNYDER'S CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>PERRY CO. PA.</u>	
24. FUNERAL DIRECTOR <u>K. MADISON MITCHELL, HARVE DE GRACE MD.</u>				25. REC'D BY REGISTRAR <u>MAR 20 1967</u>		25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03691

03685

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cabarrus</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harrison</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Nannapolis</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harrison Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James W</u> Middle <u>Stowe</u> Last <u>Stowe</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/1937</u>
9. AGE (In years last birthday) <u>29</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cabarrus N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel B. Stowe</u>		14. MOTHER'S MAIDEN NAME <u>Lula Fritner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Whitney Funeral Home</u>		Address <u>Nannapolis N.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture L. femur</u> (c) <u>Multiple internal injuries</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto A accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3-24-67</u> p.m. <u>  </u>	20d. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 40</u>	20f. (City or town) (County) (State) <u>Joppa MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		Address (Street, city, town, or county) <u>3-24-67</u>	
23a. BURIAL, CREMATION, Removal (Specify)	23b. DATE THEREOF <u>3/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Roberta Methodist Church</u>	23d. LOCATION (City, town or county) (State) <u>Concord N.C.</u>
24. FUNERAL DIRECTOR <u>Funerary Co. Harold Elmer M.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>MAR 28 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03692

CERTIFICATE OF DEATH

03686

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSP.</u>				e. STREET ADDRESS <u>303 OAK ST</u>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>BASIL</u> Middle <u>Taylor</u> Last				4. DATE OF DEATH Month <u>MARCH</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 26, 1908</u>		9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pocomoke, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frank T. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Flossie Foxwell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>24-18-1307</u>		17. INFORMANT <u>Mrs. Laura M. Taylor</u> Address <u>same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericardial tamponade</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Dissecting aneurysm of aorta &amp; rupture</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>4 hrs</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 9, 1967</u> to <u>MARCH 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 11, 1967</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard J. Coffey</u>				22b. DATE SIGNED <u>MAR 11, 1967</u>		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/14/1967</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Belair Memorial Garden</u>		23d. LOCATION (City, town or county) (State) <u>Belair, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Tinkum &amp; Sons</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25c. DATE <u>MAR 13 1967</u>				25d. ADDRESS <u>Baltimore, Md.</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03693

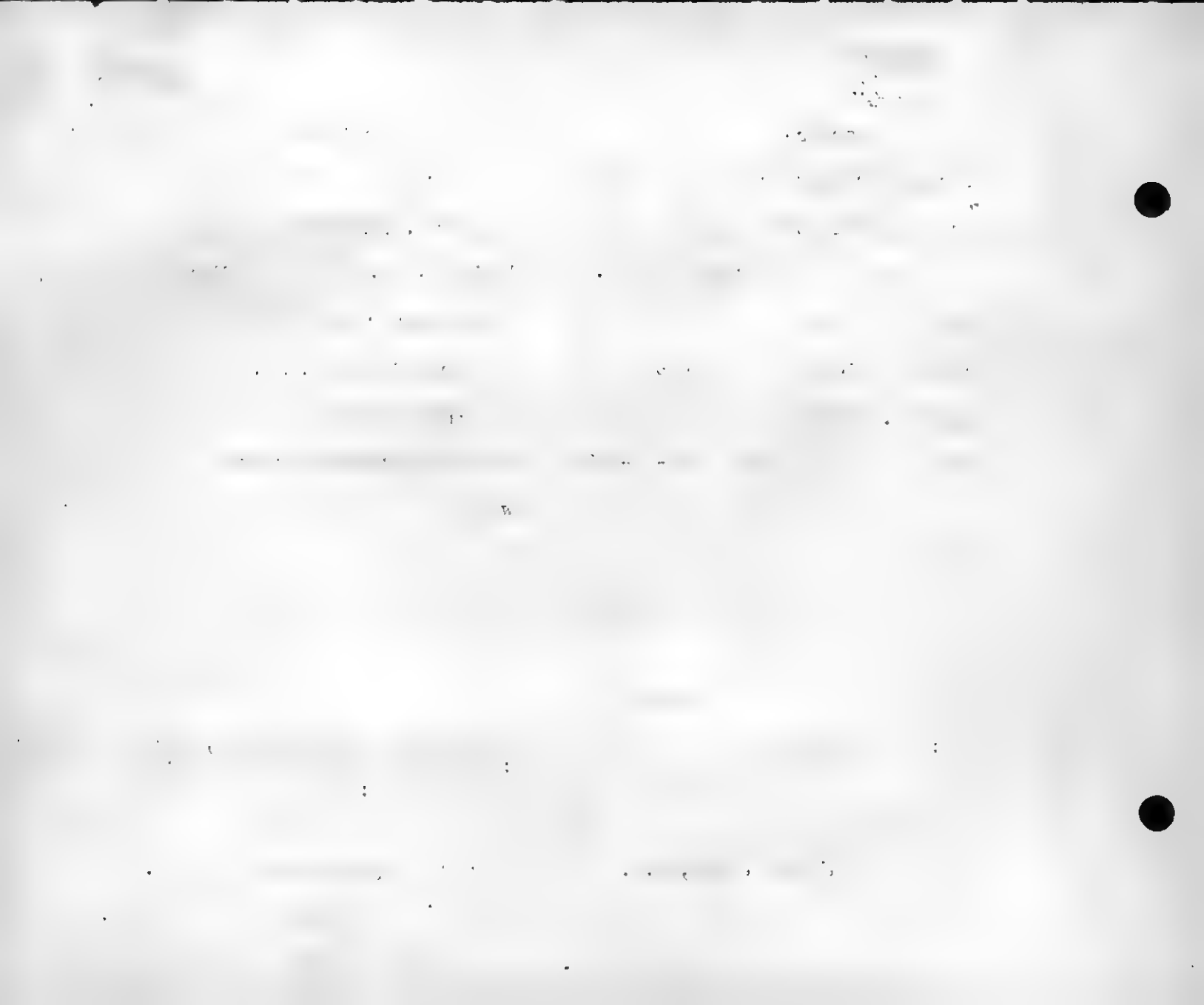
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03687

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b>				c. LENGTH OF STAY IN 1b <b>UNK</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kirk Army Hospital</b>				d. STREET ADDRESS <b>RD #3, Box 165</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Warren H. THOMPSON, SR.</b>		First Middle Last		4. DATE OF DEATH <b>March 14 1967</b>		Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 November 1920</b>	9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Equipment Tester</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept of Army</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harford County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eugene L. Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Lomyie Woods</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1942-1943 214-18-5235</b>		17. INFORMANT <b>Civilian Personnel Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia by Drowning</b> DUE TO (b) <b>110</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>110</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 Hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Unknown</b>					
20c. TIME OF INJURY Month, Day, Year <b>9:55 am 14 Mar 1967</b>		20d. INJURY OCCURRED <b>While at work</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chesapeake Bay</b>		20f. (City or town) (County) (State) <b>Aberdeen PG, Harford, Maryland</b>	
21. I certify that (I) <del>the deceased</del> attended the deceased from <b>2:55 14 Mar 1967</b> , to <b>0255 14 Mar 1967</b> , that (I) <del>was</del> last saw the deceased alive on <b>DOA 14 Mar 1967</b> , and that death occurred at <b>2:55 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Jether Jones</b>				22b. DATE SIGNED <b>3/14/67</b>		22c. PHYSICIAN'S NAME (Type) <b>JETHER JONES, M.D.</b>	
22d. ADDRESS <b>Kirk Army Hospital, APG, Md.</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3/18/67</b>		23b. DATE THEREOF <b>3/18/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chesapeake Bay</b>		23d. LOCATION (City, town or county) (State) <b>Aberdeen Md.</b>	
24. FUNERAL DIRECTOR <b>Charles Judge</b>				25a. REC'D BY REGISTRAR <b>MAR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

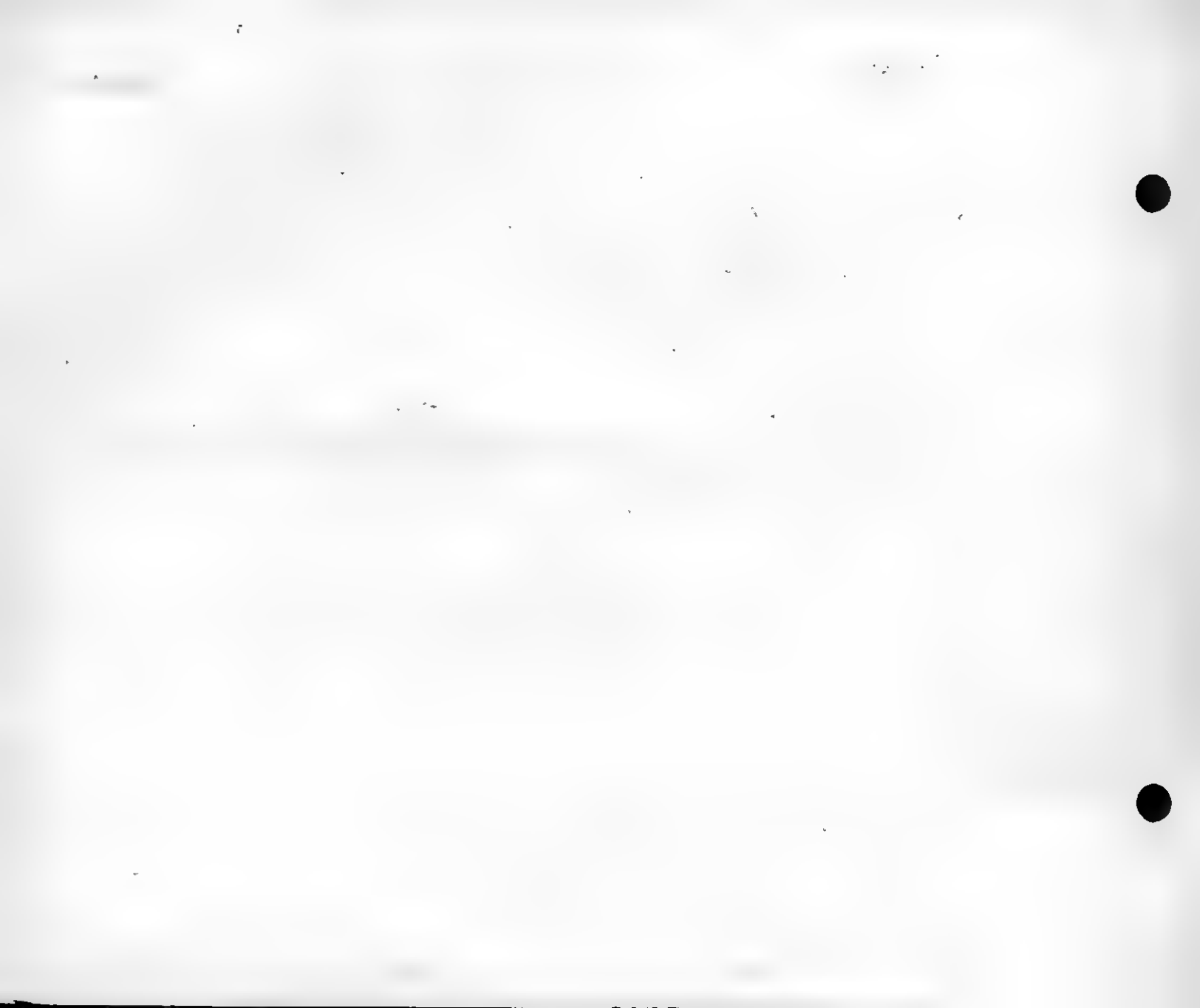
03694

03688

1 PLACE OF DEATH a COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res. or if in institution (mission) a STATE <u>New York</u> b COUNTY <u>Queens Co.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c LENGTH OF STAY IN 1b <u>5</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Hartford Memorial Hospital</u>		d STREET ADDRESS <u>2335 Walton Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Sarah Valencia</u>		4 DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MAR. 7, 1893</u>
9a US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Worker</u>		9b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11 BIRTHPLACE (State or foreign country) <u>N.Y. City</u>
13 FATHER'S NAME <u>Morris Holzman</u>		14 MOTHER'S MAIDEN NAME <u>Sola</u>	
15 WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>		16 SOC. A. SECURITY NO. <u>082-16-1989A</u>	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malignant Tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>1770</u> (c) <u>—</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION OR OTHER DISPOSAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Mar. 23, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Bayview Cem.</u>		23d LOCATION (City or town) (County) (State) <u>Queens Co. N.Y.</u>	
24 FUNERAL DIRECTOR <u>R. Madison Mitchell, Harrisburg, Md.</u>		25a REC'D BY REGISTRAR <u>MAR 22 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03695

## CERTIFICATE OF DEATH

03689

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u> c. LENGTH OF STAY IN 1b <u>14 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u> d. STREET ADDRESS <u>130 WILSON ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>D.</u> Last <u>WILLIAMS</u>				4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 29, 1878</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>W. VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Purlev L. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth P. Corfee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-48-9214</u>		17. INFORMANT <u>Roger E. Williams, Haver de Grace, Md.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> DUE TO (b) <u>PARALYTIC ILEUS</u> DUE TO (c) <u>CHRONIC DUODENAL ULCER</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEMORRHOIDS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>27 hrs</u> <u>48 hrs</u> <u>WKS.</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 25, 1967</u> to <u>MARCH 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 10, 1967</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles J. Foley Jr.</u>				22b. DATE SIGNED <u>  </u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles J. Foley Jr.</u>				22d. ADDRESS <u>Haver de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-13-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pont Deposit, Md.</u>	
24. FUNERAL DIRECTOR <u>W. A. Patterson &amp; Son, Perryville, Md.</u>				25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>			
DATE <u>MAR 15 1967</u>				DATE <u>  </u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harre-de-Grace</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		d. STREET ADDRESS <b>5558 Trimble Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Jessie Margaret Williams</b>		4. DATE OF DEATH Month <b>3</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Mc Dairmont</b>		14. MOTHER'S MAIDEN NAME <b>Anna Franke</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-44-8138</b>	
17. INFORMANT <b>Edgar M. Williams</b>		Address <b>5558 Trimble Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-</b> (c) <b>-</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) Diabetes mellitus, uncontrolled (2) A.S.C.V.D.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/23, 1967</b> to <b>3/23, 1967</b> , that (I) (we) last saw the deceased alive on <b>3/23/1967</b> , and that death occurred at <b>4:50 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Edward C. Lee</b> M.D.		22b. DATE SIGNED <b>3/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward C. Lee, M.D.</b>		22d. ADDRESS <b>Harre-de-Grace, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar. 25, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Bel Air Harford Md</b>
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md. 21006</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G386 3/13/67

03697

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03691

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <del>HARFORD</del> <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>North East</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		d. STREET ADDRESS <b>Box 121</b>	
3. NAME OF DECEASED (Type or print) <b>MILDRED V. WILLIAMS</b>		4. DATE OF DEATH Month <b>3</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 8, 1922</b>
9. AGE (In years lost, high day) <b>44 47/8</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry A. Kinslow</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Clark</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-30-3136</b>	
17. INFORMANT <b>Howard P. Williams-</b>		Address <b>North East Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>981X</b> IMMEDIATE CAUSE (a) <b>Massive internal bleeding</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gunshot wound of abdomen</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by son-in-law</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:30 p.m. 3 5 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Port Deposit Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>3=6=67</b>	
ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>WERNER U. SPITZ, M.D.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>3/10/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cem.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Zion Md.</b>		24. FUNERAL DIRECTOR <b>Calvin Bell</b> 909 Poplar St.	
25a. REC'D BY REGISTRAR <b>8</b> 1967		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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*[Handwritten signature]*

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03698

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03692

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Fallston</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Fallston</b> 12-1	
c. LENGTH OF STAY IN lb <b>2 years</b>		d. STREET ADDRESS <b>2205 Harford Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2205 Harford Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John William Lester Zimmerman</b>		4. DATE OF DEATH <b>March 23, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (1894) <b>July 13, 1894</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Heating</b>	
11. BIRTHPLACE (State or foreign country) <b>York, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Zimmerman</b>		14. MOTHER'S MAIDEN NAME <b>Sara E. List</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>175-10-9523</b>	
17. INFORMANT (Son-in-law) <b>Mr. Bruce Allen</b>		18. ADDRESS (Street, city, town, or county) <b>2205 Harford Road Fallston, Maryland 21047</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>451X Aneurysm Abdominal Aorta</b> DUE TO (b) <b>Arteriosclerotic C V Disease</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gerald C. Palmer</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Bel Air, Md. 21014</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-25-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. ROSE CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>YORK YORK Co. PA.</b>	
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	
ADDRESS <b>W. Broadway &amp; Williams Bel Air, Maryland 21014</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

Joseph William Foster

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